April 14, 2010

The Honorable Robert D. Drain,

I am writing to you regarding my Administrative Claim # 20017, for Andrew C. Gregos, against Delphi. My claim, for the amount of $528,443.24 was filed on November 5, 2009. This included the lost disability income that Delphi quit paying in August of 2009 until I turn age 65 and estimated attorney fees.

A hearing is scheduled for April 22, 2010 and that is the reason for this letter.

I am providing the following information in support of my Claim:

1.) Letter from my ERISA Attorney to Delphi, dated November 16, 2009 (2 pages)
2.) Affidavit dated November 12, 2009 (2 pages)
3.) Affidavit that is being April 14, 2010 to MetLife (5 pages)
4.) Medical documentation given to Delphi Medical on August 14, 2009 (48 pages)
5.) Medix Evaluation Services report dated July 8, 2008. Delphi selected them as an independent doctor to review my situation. (3 pages)

I disagree with the treatment of the claim and believe that it is valid. I expect that my claim be allowed and paid in full.

Delphi's position is that this is a severance claim. I believe that they are acting irresponsibly; they are acting as the evaluator and as the payer of this claim. This appears to be a conflict of interest.

I am pursuing legal action for an ERISA violation.

Delphi, MetLife and the National benefit center have ignored requests for documentation, ignored appeals and instead brought me back into medical with the sole intention of severing me. This was against doctor's orders, including the decision of the independent doctor they selected and without even an examination by the Delphi Doctor on the day they terminated me, August 14, 2009.

Please rule this claim in my favor for the full amount requested

Thank you,

Andrew C. Gregos
3076 Crescent Dr.
Warren, Ohio 44483
330-393-3328

Cc: DPH Holdings Corp.
5725 Delphi Drive
Troy, Michigan 48098
Attn: President

Skadden, Arps, Slate, Meagher, & Flom LLP
155 North Wacker Dr.
Chicago, Illinois 60606
Attn: John Wm Butler Jr., John K. Lyons and Joseph N. Wharton

COPY

Law Office of
MICHAEL A. MALYUK
Attorneys at Law

Michael A. Malyuk

Scott M. Kolligian
Associate

November 16, 2009

Delphi
World Headquarters and Customer Center
Attn: Brian C. Studer
Manager Defined Benefit Plans
Employee Benefits
5725 Delphi Drive
Troy, Michigan 48098-2815

Re: Andrew Gregos Disability Retirement/Current Appeal

Dear Mr. Studer:

In response to your last communication with me where you indicated that Mr. Gregos had returned to work, I want to advise you that you have been misinformed. What really happened was that Mr. Gregos was asked to come to see the Delphi doctor, which he did, and was examined. Mr. Gregos advises that he did not examine but only talked to him, and learned that the doctor felt he could return to employment.

Immediately thereafter, Representatives from the Personnel Department met Mr. Gregos and indicated to him that there were no positions available, but that he was eligible for a severance package.

Mr. Gregos did not return to any job, was never laid off, and did not sign any severance package documentation. The idea that Delphi may try to argue a return to work because he visited the doctor would be ludicrous.

Attached please find the Affidavit of Mr. Gregos as well as a copy of the Social Security disability decision finding him, clearly, less than sedentary and unable to perform any occupation in the National Economy.

I am also enclosing for your information a letter from MetLife indicating that the EDB would be reduced but this is not a letter indicating that it would be eliminated. Obviously, there is confusion between Delphi and MetLife as to the payments of the extended or long-term disability benefits and your clarification is requested.

2020 Front Street, Suite 305, Cuyahoga Falls, OH 44221
mike@malyuk.com • 330.929.9700 • Fax 330.929.9720 • scott@malyuk.com

I am enclosing a letter to the National Benefits Center dated September 24, 2009, where I asked for the complete file from that side of this matter, but I have received no word. I am requesting that all files accumulated under any Delphi program be considered one file and that you advise with regard to other medical files that may be available other than the one sent to me by letter of October 9, 2009 and signed by you.

Again, I will be providing more information but I urge you to keep your file open and to render the appropriate decision after I have submitted the documentation.

Thank you very much.

Very truly yours,

Michael A. Malyuk
MAM/es
enc.

State of Ohio)
) ss:
County of Summit)

IN THE MATTER OF ANDREW C. GREGOS
REF: Long-Term Disability Matter

AFFIDAVIT

1. I am Andrew C. Gregos and I am an applicant for disability benefits through the Delphi Corporation;

2. In August 2009, I received word that I was to report to a Delphi doctor for purposes of an examination for review of my disability status;

3. I did report to that doctor at the Delphi medical facility on North River Road in Warren, Ohio, and provided him 47 pages of medical documents including my Social Security Disability award. The doctor and I had a discussion concerning my condition that lasted approximately thirty (30) minutes but he never examined me. He told me that no doctor would heal me and that I must heal myself; he also told me several times that I was like the Iraq war vet that lost his legs and needed to quit sitting at home feeling sorry for myself and get on with my life;

4. After the discussion with the doctor, he indicated to me that I should return to work with the restrictions of sitting for one-half (½) hour and standing for one (1) hour; shortly thereafter a personnel representative met with me and indicated that there were no jobs for me but offered me a severance package, which I declined then and continue to decline;

5. That my long-term disability or extended disability benefits were paid up through August 13, 2009, the day before I met with the Delphi doctor and thereafter I have received checks purportedly for layoff and for severance and I have not cashed these checks. I do not agree with the reasoning for the issuance of these checks and believe that they are to undermine my effort for disability and to exclude me from the benefit programs;

6. That I have not worked at Delphi since September 15, 2006, and have been rendered totally disabled by the Social Security Administration in a recent decision;

7. That my physical problems have worsened over time, not improved, and that I continue to treat for my medical problems that are outlined in the record.

FURTHER AFFIANT SAYETH NAUGHT.

Andrew C. Gregos

Sworn to and subscribed in my presence this 12 day of November, 2009.

Notary Public

MICHAEL A. MALYUK, Attorney-At-Law
Notary Public - State of Ohio
My commission has no expiration date
Section 147.03 R.C.

State of Ohio)
) ss:
County of Summit)

IN THE MATTER OF ANDREW C. GREGOS
REF: Long-Term Disability Matter

AFFIDAVIT

1. I am Andrew C. Gregos and I am an applicant for disability benefits through the Delphi Corporation;

2. I have provided a supplemental statement under oath and it is attached hereto and consists of my testimony for clarification of the record;

3. I have carefully examined my statement attached hereto and it is true to the best of my belief and knowledge and I do submit it in support of my disability application.

FURTHER AFFIANT SAYETH NAUGHT.

Andrew C. Gregos

Sworn to and subscribed in my presence this 13 day of April, 2010.

Notary Public

Sworn Statement of Andrew C. Gregos
April 8, 2010
Questions by Attorney Michael A. Malyuk and Answers by Andrew C. Gregos

M: Attorney Michael Malyuk
A: Andrew C. Gregos

M: For the record, your name and address?

A: Andrew C. Gregos, 3076 Crescent Drive NE, Warren, OH 44483

M: You understand that you are giving this statement for the record in your disability application that has recently been denied with a final letter from MetLife. Is that true?

A: Yes.

M: Now in that letter from MetLife, and that is the letter dated February 17, 2010, and on pages 2 and 3, MetLife references your visit to the Plant Medical Department; my question Mr. Gregos is how did it come about that you visited the Plant Medical Department?

A: I received a telephone call from a Delphi nurse, I believe her name was Jackie and said that they wanted to review my status and my case. She stated that Dr. Jones, the doctor that did my knee surgery had approved me to return to work. I stated that I understood that my sick leave was still in effect for my back and not scheduled for review until December. She stated that they wanted me to come in to see the medical doctor and bring any documentation that would support my claim, which I did.

M: At that time, and prior to your visit to the Plant Medical Department, were you receiving your disability benefits?

A: Yes.

M: Now do you remember that we sent an Affidavit to MetLife previously concerning this visit at the Plant Medical Department?

A: Yes, I do.

M: Now I don't want to go over everything that we previously submitted in that Affidavit, but I do want to clarify a couple of things. That Affidavit was sent by me to Brian Studer at Delphi believing that anything to Brian Studer would also be in the MetLife file and in this letter of 2/17/10, on page 3, MetLife indicates that on August 14, 2009, you reported to the Plant Medical Department and was approved for return to work with restrictions. Now my question is do you know what restrictions?

Andrew C Gregos

A: I was told by Dr. Tochtenhagen, the medical doctor at Delphi that Dr. Mikula, who is my previous general physician, has said that I was able to sit for a half an hour and stand for an hour and that he was going with those restrictions even though I told him that Dr. Mikula was no longer my doctor. I provided Dr. Tochtenhagen a copy of the "Attending Physician's Statement of Disability" completed by my current doctor which stated I was totally disabled and could not perform restricted work. He completely ignored this statement.

M: Now just so everything is clear, because I disputed in my letter to Delphi, I disputed that fact that you had worked, just so it is clear, did you work at all that day when you went to the Plant Medical Department?

A: No. I left medical, walked out through the clock area and returned to my car and returned home.

M: And just so it is also clear about this examination on 8/14/09, did he examine you in any way in terms of reflexes, touching you in any way, anything?

A: None whatsoever.

M: Now in that same letter of 2/17/10, MetLife makes reference to Dr. Catterlin indicating that he had completed a statement on August 14, 2009, which looks like the same date you went to the Plant Medical Department and they say here that he did not indicate a diagnosis. Now is it not true that we had dealt with this before and in fact sent Catterlin's document in again to them and that MetLife acknowledged that in fact that he did indicate a diagnosis.

A: Yes, we had sent that along with other documents that also reflected the diagnosis of degenerative disc disease.

M: Now so we are clear about your treatment, at the time you visited the Plant Medical Department as you described, who were you treating with?

A: I was treating with Dr. Catterlin as a general family type doctor, Dr. Hart, Dr. Sahgal, Dr. Goldner, Dr. Mullin, Eschman Physical Therapy.

M: Now were you restricted by any of these doctors from doing anything or what was the advice from any of these doctors regarding activity or work? Let's take work first, were you allowed to work eight (8) hours a day, five (5) days a week by any of these doctors?

A: No. None of them, in fact all of them have said that I was unable to function in a regular schedule capacity for any length of time.

M: Ok, now what about doing any kind of activities, what were the restrictions or what was the advice regarding that by any particular doctor?

A: Pretty much all the doctors had said that I need to stay active, I need to keep moving, keep thin, continue to do general maintenance type things around the house, cutting the grass, working around the house, try to see what creates the pain and then how to deal with it. Take frequent breaks, stretch, lay down, walk. If the pain increases, refrain from doing that activity.

M: Now, have you with that advice, have you tried to be active and do those things?

A: Yes. In addition, there have been several occasions after treatments, that I was instructed to "work it hard" and also do things that I know cause pain in order to determine if the treatment was successful. So far, there has been no significant or long-term relief from any of these treatments.

M: And have you had to pace yourself and only work in small increments?

A: Absolutely.

M: So like in a typical day, how much time do you think you would actually be active in doing what we would call work, you know doing something?

A: I would say on average, probably no more than forty-five (45) minutes to an hour a day.

M: Now, with regard to that and you indicated an average, are there days when you can do more, like a couple of hours of work, if you are feeling a little bit better over the course of a whole day?

A: Yes. Usually I have to wait until the pain subsides a little, I may have to lay down, I go into my traction units or I do a stretching regime. Usually it is better after I am at physical therapy, which I attend typically twice a week and that runs two (2) to three (3) hours a visit.

M: Are there some days when you don't even accomplish an hours worth of work because of your problems?

A: There are days when I don't do anything. I truly just lay down and not perform any physical activity. This is very common on the days where I sleep less than a few hours.

M: Are you currently in physical therapy?

A: Yes, I am.

M: How long have you been in physical therapy?

A: I started in 2002 and continued off and on through about 2005 and in about 2006 I started regularly attending therapy and I have been in therapy now for probably about a year and a half (1/2), two (2) years constantly.

M: Did you tell the doctor at the Plant Medical Department in August 2009 that you were in therapy?

A: Yes, I did, in fact I provided him with documentation from the therapist that included evaluations and a summary that states the classification considers me as disabled and I am unable to function.

M: So from an overall standpoint, what has been the progress and what kind of prognosis do we have from the doctors?

A: The prognosis is not good. The doctors have told me to continue with physical therapy, continue with the stretching regimes, to try and minimize the damage. The prognosis is that it is going to continue to get worse and there is really nothing they can do. Artificial discs aren't available or approved for multi-level problems such as mine, stem cell research is probably ten (10) years away, so as the doctor I went to just recently said the best thing he can do is to try to make me comfortable.

End of Interview

Medix Evaluation Services
60 N. Canfield-Niles Rd. Ste 500
Youngstown, OH 44515
(330) 792-1973

July 8, 2008

RE: Andrew C. Gregos
NO: 980710010278

Andrew C. Gregos is a 52-year-old male, was seen at Medix Evaluation Services, per your request, on July 8, 2008, for intervertebral disc disorders and neck pain. He was first seen by me on March 23, 2007 for evaluation of DJD of cervical, thoracic and lumbar spine and cervical disc displacement.
The employee's occupational duties are: Engineer

PRESENT HISTORY:
Since he has been here on his last visit, nothing has really transpired to change his condition. He has been told he has intervertebral disc disorder in the lower back and he has to have three discs replaced. The FDA has approved only one disc at a time and the surgeon, Dr. Brian Mullen, at Mt. Carmel East in Columbus does not want to do three times surgery, so they are waiting for FDA approval to replace three discs and this is still experimental in this country, but it has been approved in Germany and all this reference has been made in the previous exam.

He also had cervical fusion and that has left him with still some numbness and tingling in both hands, but range and mobility is good. He is under the care of Dr. Brian Mullen at Mt. Carmel East, who is a neurosurgeon in Columbus. He only sees him on a yearly basis until technology and surgical approaches have improved significantly. He is also the patient of Dr. Dechellis here in town, whom he sees basically for therapy and basically for medication, etc.

CHIEF COMPLAINT:
Intervertebral disc disorders and neck pain. His complaints are that he has lower back pain that radiates down his right leg to his foot, mostly right and sometimes left. Also still has a little radicular pain, numbness and tingling in both hands, depending on position. He has completed physical therapy and is not a candidate for anything else in the way of epidurals, etc., and is awaiting surgery. He has pain and limited ability to sit to stand, weakness in his hands and lower extremities.

RE: Andrew C. Gregos
NO: 980710010278
PAGE 2

Incidentally and he is not being seen for this today, he miss stepped and sustained a twisting injury to his left knee, for which he is in a knee immobilizer and he presently on crutches. This is not what he is being seen for, but it should be noted that he also has that problem and he is accompanied by his wife.

MEDICATION:
His medications at this point are Lisinopril, Vytorin, aspirin, Vicodin as needed.

PAST HISTORY: There is no worker's comp. He is an engineering manager. There is no history of worker's comp. His problems with his neck and lower back are probably on a hereditary basis, since his dad, he says, had that and has not had any injuries or whatever else. He has not had another MRI. MRI scans were reviewed last time and they showed degenerative disc disease L3-4, L4-5, L5-S1 and status post cervical fusionC5-6, C6-7 and upper thoracic degenerative disc disease.

PHYSICAL EXAMINATION:
HEIGHT: 6'1" WEIGHT: 203 lbs.
This is a well-developed, well-nourished gentleman, oriented, right hand dominant. He is 52-years of age. Straight leg raising is positive bilaterally at 90 degrees. Range of motion to his lumbar spine he is about 6" from touching his toes. He is somewhat limited also because of the knee brace on that left side. Extension and lateral bending are about 50% of normal. Lumbosacral spasm is 3+. He has minimal tenderness in the sciatic notch and SI joints. DTR's are equal and symmetrical in the lower extremities. Cervical spine has surprisingly good range of motion. There is a well healed anterior cervical scar. DTR's are 2+ equal and symmetrical. Radial and median nerve are intact. Good pinch, grip and grasp. Really not much in the C-spine, but the lumbar spine is most of his debility and problem.

IMPRESSION:
This gentleman is under the care of a neurosurgeon. His surgery has not been approved. He needs intervertebral disc replacements at three levels and this is not approved as yet. He is in limbo. His surgery has not been approved by the FDA and he is in a hold pattern. There is nothing to do in the way of treatment. There is nothing to do other than supportive. There is no therapy, nothing else. he is under the care of the neurosurgeon.

RE: Andrew C. Gregos
NO: 980710010278
PAGE 3

CONCLUSION:
Based on these findings and the lack there of, of anticipated surgery, I find him unfit for an indefinite period of time, as he says, until technology catches up to his condition. There is no way he can do his job.

Sincerely,

Robert J. Cuttica, M.D.
Orthopedic Specialist

RJC/pds

1/3

SOCIAL SECURITY ADMINISTRATION

Refer To: 277-54-0489

Office of Disability Adjudication and Review
SSA ODAR Hearing Office
300 Seven Fields Bldg.
Suite 200
Mars, PA 16046

Date: May 1, 2009

Andrew C. Gregos
3076 Crescent Dr. NE
Warren, OH 44483

NOTICE OF ATTORNEY ADVISOR DECISION – FULLY FAVORABLE

As a result of an additional review, we are able to make a fully favorable medical decision and find that you meet the medical requirements for disability benefits. The onset of your disability is established as of September 16, 2006.

Therefore, it is not necessary to have your case decided at the hearing level by an Administrative Law Judge.

This Decision is Fully Favorable To You

Another office will process the decision and send you a letter about your benefits. We have not yet made a decision about whether you meet the nonmedical requirements, but we will make that decision soon. You will soon get a notice about the amount of your payments if you meet the nonmedical requirements.

DO NOT HAVE INCOME THAT LIMITS BEN.

If you agree with our revised decision, you need take no further action and your hearing request will be dismissed.

If You Disagree With The Decision

If you disagree with our revised decision, you may request that the Office of Disability Adjudication and Review proceed with your pending request for hearing. Your request should be made in writing and filed within 30 days from the mailing date of this notice. Your request may be filed with any Social Security office.

See Next Page

functional capacity, age, education, and work experience (20 CFR 404.1512(g) and 404.1560(c)).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After careful consideration of the entire record, I make the following findings:

1. The claimant's date last insured is December 31, 2011.

2. The claimant has not engaged in substantial gainful activity since September 16, 2006, the alleged onset date (20 CFR 404.1520(b) and 404.1571 *et seq.*).

A close review of the Social Security Administration's certified earnings record shows the claimant did receive income after his alleged onset date. However, said income represents deferred compensation and/or third party disability benefits which the claimant received from Metropolitan Life Insurance Company. Accordingly, I find the claimant has not engaged in substantial gainful activity since his alleged onset date.

3. The claimant has the following severe impairment(s): degenerative disc disease of the cervical and lumbar spine, degenerative arthritis of the spine, bilateral neuroforaminal narrowing of the cervical spine (status post cervical discectomy and fusion), osteoarthritis of the left knee, bilateral carpal tunnel syndrome, and hypertension (20 CFR 404.1520(c)).

The combination of these medically determinable impairments significantly limits the claimant's ability to perform basic work activities. As explained below, the restrictions associated with these impairments prevent him from performing the full range of light exertional work activities. They are therefore severe within the meaning of 20 CFR 404.1520(c) (see Drs. Mullin, Patel, and DeChellis, and Humility of Mary Health Partners – St. Joseph Health Center).

4. The claimant does not have an impairment or combination of impairments that meets or medically equals one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525 and 404.1526).

In making this finding, I have considered sections 1.00 *Musculoskeletal System* and 11.00 *Neurological* of the Medical Listings. The medical source opinions of record do not establish the existence of an impairment or combination of impairments that meet or medically equal a listed impairment in Appendix 1 of the regulations.

5. The claimant has the residual functional capacity to perform light work as defined in 20 CFR 404.1567(b) except he: must be in the supine position for 50% of a normal workday; is precluded from climbing ladders, ropes, and scaffolds; cannot perform more than occasional ramp/stair climbing, balancing, stooping, kneeling, crouching, or crawling; he must avoid upper extremity grasping, handling, and reaching; and he cannot work within a schedule or at a consistent pace, eight hours a day, five days a week, secondary to her well documented symptomatology.

See Next Page

1822 M7

Social Security Administration
Retirement, Survivors, and Disability Insurance
Notice of Award

Office of Central
Operations
1500 Woodlawn Drive
Baltimore, Maryland 21241-1500
Date: July 14, 2009
Claim Number: 277-54-0489 HA

ANDREW C GREGOS
3076 CRESCENT DR NE
WARREN, OH 44483-6302

We are writing to let you know that you are entitled to monthly disability benefits from Social Security beginning March 2007.

What We Will Pay

- Your first payment is for
- This is the money you are due through June 2009.
- After that, you will receive on or about the third Wednesday of each month.
- Your monthly payments will go to the financial institution you selected.

Your Benefits

The following chart shows your benefit amount(s) before any deductions or rounding. The amount you actually receive may differ from your full benefit amount. When we figure how much to pay you, we must deduct certain amounts, such as Medicare premiums and workers' compensation offset. We must also round down to the nearest dollar.

Beginning Date	Benefit Amount	Reason
March 2007	$	Entitlement began
December 2007	$	Cost-of-living adjustment
December 2008	$	Cost-of-living adjustment

SEE NEXT PAGE

Aug. 14. 2009 9:54AM ORS CATTERLIN No. 2117 P. 1

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

PATIENT'S NAME: ANDREW C GREGOS Claim #: [redacted]

The patient is responsible for the completion of the form without expense to the Insurance Company.

1. Present Condition:

(a) Patient is: Ambulatory (X) Bed confined ( ) House Confined ( ) Hospital confined ( )

(b) Patient's symptoms: Cervical Neck, lumbar pain

(c) Objective findings (include results of current X-rays, E.K.G's or any other special tests)
Spasm to the @ C6 posterior cervical muscle more cervical, lumbar

(d) Diagnosis:

2. Treatment:

(a) Date of first visit: 6/17/09 (b) Date of last visit 8/12/09

(c) Frequency of visits: Weekly ( ) Monthly (X) Other

(d) When did you last examine patient?

3. Prognosis: Recovered ( ) Improved ( ) Unimproved (X) Retrogressed ( )

4. Extent of Disability: For Any Occupation For Employee's Regular Occupation

(a) Is patient now totally disabled? Yes (X) No ( ) Yes (X) No ( )

(b) If yes, when do you think patient will be able to resume any work?

Approximate Date... Mo____ Day____ Year____ Mo____ Day____ Year____

Never (X)

(c) If no, when was patient able to go to work?

Mo____ Day____ Year____ Mo____ Day____ Year____

(d) Is the patient able to perform restricted work? Yes ( ) No (X)

Restrictions:

(e) Is the patient suitable for a rehabilitation program? Yes ( ) No (X)

5. Mental Condition: Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes (X) No ( )

6. Remarks:

Physician's name (please type or print) RICHARD L CATTERLIN D.O.

Office address 1360 N. CANFIELD-NILES RD. MINERAL RIDGE OH. 44440

Specialty Board Certification FAMILY PRACTICE Phone No. ( )

Date Completed 8/14/09 Physician's signature

Revised 6/07 CH111-EDS-DSL (6107)

AUG-13-2009 THU 06:11 PM ESCHMAN P T FAX:3303725841 P. 001

LORDEX Spine Care Center

Eschman Physical Therapy, LLC
330-372-5800 - Fax 330-372-5841
2581 North Road NE, Warren, OH 44483
www.EschmanPT.com

Fax to Doctor: DR. THOMAS JONES Fax No: 330-856-6186

Re-Eval Patient Andrew Gregos Net 46 Cli 1 Acct #: 639 DOB 12/16/1955

Provider # HICN/Claim DEH920345250 44 Visits used of 999 Auth

Onset Date: 7/1/2008 1st Tx Date: 3/31/2009 Type: Script PNoteNu 6

Ref MD DR. THOMAS JONES Phone: 330-856-1070 Fax: 330-856-6186 Script Date 7/16/2009

Duration 90 Frequency 3

Tx Dx: TEAR MED MENISC KNEE-CUR

Tx Dx: JOINT PAIN-L/LEG

Tx Dx:

Physician Dx (As written on script.) ACL reconstruction 3/13/09.

Physician Dx

Current Program Manual therapy techniques for soft tissue mobilization and modalities for pain modulation. Care also includes neuromuscular reeducation and therapeutic exercise for promotion of strength, R.O.M., proprioception and posture.

Objective Progress The pt. has recently been reassessed W/ the Oswestry Back Pain Index Questionnaire to describe the intensity of pain as a very severe pain. The pt. rates the pain as 46/100 pts.indicating a severe disability level. The pt reports the most functional difficulty W/ sitting, standing, sleeping as well as traveling. R.O.M. meas show the following: flexion at T12 ranges from 97 to 113°, Norm 60°; flexion of the sacrum ranges from 58 to 67°, Norm 45°; ext. at T12 ranges from 22 to 28°, Norm 25°; extension of the sacrum ranges from 9 to 13°, Norm 10°. The pt has an obvious hypermobility throughout his T-L & L-S spine & is at significant risk of recurrent sprain/strain & repeated injury due to lack of stability.

Revised Goals
(over the course of the next 3 weeks):
1.Cont. to Decr. the pt. 's subjective C/O pain 1-2 levels on the visual analogue scale.
2.Cont. to Incr the pt. 's pain free ROM 5° w/re to spinal flexion/extension.
3.Cont. to Incr. Back m. strength w/re to flex/ext 1/2 to 1 grade.
4.Cont. to Normalize the pt's ability to walk.
5.Cont. to Decr. the pt's. score on the knee scale score 5 to 10 pt.s

Plan/Comments
The patient was reassessed on Aug13th,2009. Physical Therapy treatment will cont. 2x/wk for the next 3 wks ,pending Dr approval, for treatment as follows:
1. Therapeutice exercise for the Ex. bike or Treadmill, & gentle strengthening.
2. Neuromuscular reeducation for stretching,PRRT& CST.
3. Manual therapy techniques for soft tissue and joint mobilization techniques.
4. Therapeutic activities to improve functional performance.
5. Modalities may include US,diathermy, and/or E-stim for pain modulation.

Provider Joseph Eschman,PT,GCS Lic# PT004472 Date 8/13/2009

Physician Recommendation:
☐I have reviewed & agree with the above plan. Continue to treat at
frequency ____ a week for a duration ____ weeks or ____ visits
☐Modify the above plan to: ____

MD Signature _____ Date: _____

Please review, sign and return to:
Eschman Physical Therapy
Fax (330) 372-5841

David J. Hart, M.D.
Assistant Professor of Neurosurgery
Director, Spinal Neurosurgery
The Neurological Institute

11100 Euclid Avenue, HAN 5042
Cleveland, OH 44106
(216) 844-3008 Phone
(216) 844-1217 Fax
(216) 844-3004 Appointments

April 30, 2009

Justin Mikula, M.D.
1615 N River Rd NE #1
Warren, OH 44485

RE: Andrew Gregos
UH#: 2819485

Dear Dr. Mikula:

I saw your patient, Andrew Gregos, in neurosurgical consultation today for an additional opinion regarding his chronic lower back pain . As you may recall, Mr. Gregos is a 53-year-old Caucasian male who has a longstanding history of back pain for many years. He also has had problems with his cervical spine with neck pain radiating into the right upper extremity. He went through an extensive workup for this many years ago and was variously diagnosed with thoracic outlet syndrome or a variety of other conditions until January of 2004 when he ended up undergoing anterior cervical discectomies and fusions without anterior plating at C5-6 and C6-7 by Dr. Brantigan in Texas. He apparently had some good results from that surgery, although he does still complain of some chronic pain in the right axilla with some paresthesias and numbness in the right upper extremity that he says have been there since that time. His primary complaint currently is his lower back pain, which seems to be located somewhat asymmetrically on the right side of his lower back. He gets some stabbing pain down the right lower extremity and occasionally on the left side as well, and gets paresthesias in the right foot. Overall, he attributes 50% of his pain to his back, 47% to his right leg and 3% to his left leg. He rates his back pain and his leg pain as 7/10 on a visual analog pain scale. His pain is constantly present 24 hours a day, every day. It affects his ability to walk. It interferes with his sleep at night. He denies any bowel or bladder incontinence or perineal anesthesia. Standing and sitting make his pain markedly worse. Walking, driving, bending, lifting, getting out of a chair, coughing, sneezing, social activities and housework make it minimally worse. Sleeping has no effect. Lying down makes it better. Over the years, he has gone through extensive nonsurgical treatments for this problem, including physical therapy, muscle relaxants, bedrest, traction, aspirin, chiropractic treatment, acupuncture, steroid injections, hospitalization, heat, ice, pain medication, surgery, exercise, and TENS units. He also has undergone a wide variety of diagnostic testing, including EMGs and both cervical and lumbar discography. He has seen surgeons in the past also. Most of this diagnostic workup and testing was done between 2002 and 2005 and his last steroid injections was in 2006. It really appears that he has not had much of anything done in terms of workup or treatment in the last couple of years.

Past medical history is notable for hypertension and hypercholesterolemia.

Past surgical history includes an uvuloplasty. He just last month had an ACL repair on the left knee and he has had a dental implant placed less than two weeks ago. He also in the remote past has had an appendectomy and as a child had surgical correction of amblyopia. He also has had a vasectomy and a heel spur and neuroma removal from his foot.

Current medications include Lisinopril, Clonidine, Vytorin, aspirin 81 mg a day, Hydrocodone and Amoxicillin.

He reports an allergy to Tolectin.

Family history is noncontributory other than the fact that both of his parents died from myocardial infarctions.

Social history reveals he is married. He is an engineering manager. He is a former smoker for a few years and quit in 1979. He states that he has about a glass of wine per week and denies the use of any illicit drugs.

Review of systems is positive for joint stiffness and spasms.

On physical examination, he is a well-developed, well-nourished male appearing his stated age. He is six feet tall and weighs 202 pounds. Blood pressure is 177/96, heart rate is 69, and respiratory rate is 18. He is able to ambulate without difficulty. He has a normal gait and can heel and toe walk without difficulty. Palpation of the lumbar spine demonstrates no palpable stepoffs or deformities. Range of motion is well preserved in all directions including flexion, extension, rotation and lateral bending. There is no SI joint or sciatic notch tenderness. Manual motor testing demonstrates 5/5 strength throughout both lower extremities. There are no sensory deficits to light touch or pinprick testing. Deep tendon reflexes are symmetric and normoactive at the knees and ankles bilaterally. Toes are downgoing on Babinski testing. There is no clonus at the ankles. Straight leg raise, crossed straight leg raise and FABER test are negative.

Review of studies includes an MRI of the lumbar spine that shows evidence of significant disc degeneration, loss of disc space height and mild to moderate disc bulging with spinal canal narrowing that is mild at worst at the L3-4 and L4-5 levels. There is very mild disc degeneration at the L5-S1 level. I have available for review a copy of an EMG study that was done in July of 2003 that showed minimal carpal tunnel syndrome, but no other upper extremity abnormalities. There is a cervical discography report from 2004 that was reportedly negative at the C5-6, C6-7 and C7-T1 levels. There is also another EMG of the upper extremities from December of 2005 that also showed bilateral mild carpal tunnel syndrome and a right T1 radiculopathy.

Assessment and Plan: Mr. Gregos is a 53-year-old gentleman with chronic back pain radiating to the right lower extremity. He has some degenerative disease at L3-4 and L4-5, but most of his workup other than his recent MRI is very old. He indicates that another surgeon has told him that he would be a candidate for surgery at the L3-4, L4-5 and L5-S1 levels, but that that surgeon did not want to do an artifical disc replacement at all three levels and therefore, opted not to operate on him. I am not quite sure what to make of this story and I am not sure what the basis is for concluding that he needed the L5-S1 level operated on since it does not look particularly bad on the MRI. The patient was able to show me a note from that surgeon from a few years ago in which the surgeon reported that a lumbar discography study had been positive at L3-4 and L4-5 and negative at L5-S1. Obviously, this is essentially third hand information at this point and is out of date now anyway. I told the patient that for me to evaluate his suitability as a potential surgical candidate, he would need a significant amount of diagnostic workup, including in my opinion, a discogram evaluating the L3-4, L4-5 and L5-S1 levels with the L2-3 level as a control disc. He probably will need facet blocks to evaluate whether the facets are playing a major role in his back pain. Much of his pain does not fit the typical pattern of discogenic back pain and I would hesitate to assume that his pain is arising from the discs that look degenerated on his MRI. At this time, therefore, I have taken the liberty of referring him to the Anesthesia Pain Medicine service for workup, including discography and facet joint blocks. Obviously, these will need to be done on separate occasions to individually evaluate the affect of each intervention on the patient's pain.

Thank you for the privilege of participating in this patient's care. Please feel free to contact me with any questions or concerns.

Sincerely,

David J. Hart, M.D.
Director, Spinal Neurosurgery

DJH/lk

D 04 30 09 R 04 30 09 T 04 30 09

University Hospitals

JENNIFER KRINOV

ANDREW GREGOS **Gender:** M **DOB:** 1955-12-16 **Age:** 53
Phone: (330)393-3328 **Address:** 3076 CRESCENT DR NE WARREN OH 444836302

Result Detail

Outpatient Notes: Anesthesia

Exam Date: 07/16/2009 00:00:00 **Report Date:**
Accession Number: 380072824 **Facility:** UHCMC
Medical Record Number: 02819485 **Ordering Provider:**
Status: U **Interpreting Physician:**

UNIVERSITY HOSPITALS CASE MEDICAL CENTER
DIVISION OF PAIN MEDICINE

GREGOS, ANDREW
MRN: 02819485
DOB: 12/16/1955
DOS: 07/16/2009
LOCATION: CHAGRIN HIGHLANDS PAIN CLINIC
CHIEF COMPLAINT: Left lower back pain, right lower extremity pain.
This is a follow-up patient visit.
HPI: Patient is a 53-year-old white male with bilateral lower back pain radiating to his right lower extremity. Patient states that his pain has been ongoing for several years. Patient describes the location of his pain as across his lower back radiating down his right hip posteriorly to approximately his right knee. Patient is unaware of particular inciting events. He states that his pain is an aching dull sensation that is continuous in nature. Patient states the severity of his pain is currently a 7/10. He lists that exacerbating factors include sitting and standing for prolonged amounts of time. Alleviating factors, such as lying flat, physical therapy, and stretching, do provide him with moderate benefit. Patient was recently seen for a discogram which did not reliably reproduce his pain.
REVIEW OF SYSTEMS: All 12 systems were reviewed and are otherwise negative, apart from HPI. Patient also endorses hypertension and hyperlipidemia.
PAST MEDICAL HISTORY: No changes since previous visit.
ALLERGIES: Tolectin.
CURRENT MEDICATIONS: Clonidine, lisinopril, Vytorin, aspirin, vitamin C, multivitamin, B12, and hydrocodone.
Family history and social history are unchanged as from the previous visit.
PHYSICAL EXAM: General: Patient is a pleasant 53-year-old male, appearing stated age. He was well-developed, well-groomed in no acute distress.
HEENT: Normocephalic, atraumatic. EOMI, MMM.
Neck: Supple. Full range of motion in extension, flexion, lateral rotation.
Cardiovascular: Regular rate and rhythm. No appreciable murmurs, rubs, or gallops.
Pulmonary: Regular unlabored breathing. Lungs clear to auscultation bilaterally.
Abdominal: Soft, slender, nontender, nondistended. Positive bowel sounds.
Musculoskeletal: Normal gait. Normal heel-toe walking. No restriction in range of motion in upper or lower extremities bilaterally.
Back: Inspection - no visible scoliosis, kyphosis, or other abnormality. Full range of motion on flexion, extension, right and left bend, right and left rotation without reproduction of pain. Negative facet loading maneuvers. Patient was nontender to palpation at the spinous processes or paraspinous muscles in his upper, mid, or lower back bilaterally. Negative straight leg test bilaterally. Negative Faber test bilaterally.
Neurologic: Alert and oriented x3. Cranial nerves 2-12 are grossly intact. Motor strength in upper and lower extremities was 5/5 bilaterally. Sensory exam was intact across all dermatomes in lower extremities. Deep tendon reflexes at biceps, brachial radialis, patellar were 2+ bilaterally.

Achilles tendon was 1+ bilaterally.
Please see report on patient's discography dated June 30, 2009.
ASSESSMENT: This is a 53-year-old male with lower back pain radiating to his right lower extremity, whose history and physical exam is most consistent with lumbar degenerative disk disease with possible lumbar spondylosis. Patient's previous lumbar facet injections yielded him minimal relief however. His diagnostic discography was unable to reproduce pain at the L3-4, L4-5 and L5-S1 disks. Treatment options were discussed with the patient at this time. His pain may well be myofascial in nature. Patient was advised to set up an appointment with Dr. Siegel for evaluation and treatment. Also discussed with patient the possibility of repeating lumbar epidural steroid injections. Patient feels that his minimal relief with the previous epidural steroid injections does not warrant second trial at this juncture.
PLAN:
1. Referral to physiatrist, Dr. Siegel.
2. Patient is to continue current medication regimen.
3. Patient was encouraged to call clinic with any further questions or concerns.

Joshua Goldner, M.D.
Dictated by Caroline DeJean, MD for Joshua Goldner, M.D.
/MedQ/597445
cc: Joshua Goldner, M.D.

University Hospitals

JENNIFER KRINOV

ANDREW GREGOS **Gender:** M **DOB:** 1955-12-16 **Age:** 53
Phone: (330)393-3328 **Address:** 3076 CRESCENT DR NE WARREN OH 444836302

Result Detail

Outpatient Notes: Anesthesia

Exam Date: 07/16/2009 00:00:00 **Report Date:**
Accession Number: 381037512 **Facility:** UHCMC
Medical Record Number: 02819485 **Ordering Provider:**
Status: U **Interpreting Physician:**

UNIVERSITY HOSPITALS CASE MEDICAL CENTER
DIVISION OF PAIN MEDICINE

GREGOS, ANDREW
MRN: 02819485
DOB: 12/16/1955
DOS: 07/16/2009
LOCATION: 02819485699

This 53-year-old male engineer who was in his usual state of health, which means working and teaching martial arts, had the usual wear and tear associated with it. About 5 or 6 years ago started having pain in the neck with radiation into the right upper extremity, difficulty with sensation in the right hand, difficulty with grabbing things and holding things and pain was interfering with his daily work. At this time did not notice any difficulty walking. He did not notice any problems with bladder or bowel or sexual function. However, it was elected at that time, based on the tests done, that he needed a cervical decompression and fusion which was performed. He had the surgery done December 12, 2004, with definite relief in pain and definite relief in tingling and numbness however, the right upper extremity weakness has persisted and he still has difficulty grabbing onto things, opening jars. He is right-handed and he states that when things get difficult he results to using his left hand. No balance problems. While this was going on he also has a long history of low back pain. His low back pain precedes the neck pain. This back pain was in the small of his back, radiating, most of the time it will be a dull ache which was aggravated by sitting, he could hardly sit for more than a half an hour and walking became difficult mainly because of back discomfort. This pain generally would be on 5-6 with frequent exacerbations to 7 and 8 and infrequent exacerbations to 10. He cannot put his finger on what would make things worse, at least the exacerbation to 7-8 with mostly he a function of either standing or sitting he was in pain. Again no difficulty with his sexual function. No bladder discomfort. No bowel discomfort.
The patient has seen on a lot of doctors in the country, in Europe and just about everybody in the back have commented on the fact that he has lumbar degenerative disease which is affecting mostly L4-L5, S1 but nobody has boldly decided to operate on him and rightly so. He has had diskograms done. The last diskogram was done by Dr. Goldner, who strangely, according to the patient, had some difficulty doing the procedure but after the procedure the patient felt better rather than worse and then the pain has come back. Again no bladder or bowel problems. The patient denies any history of diabetes. No arthritis. He is hypertensive. No heart attacks. Functionally he has difficulty sitting for long periods of time. He has difficulty walking for long periods of time. A long period means half an hour or so. He also is able to put his pants on standing up. He puts his under pants on standing up. He is able to tie his laces, put his socks on. He prefers to take baths mainly because that gives him relief because of the warm water and also he has a Jacuzzi. He has really very little difficulty getting in and out of the tub. The most difficulty he has is going up the stairs in his house which is 14 steps and he can hardly go 5/6 steps up before he starts to hurt and has to stop. This is becoming more disarming for him. Other than that he has had arthroscopic surgery on his left knee for meniscus and ACL problems.

SOCIAL HISTORY: The patient does not smoke. Drinks socially and does not do any drugs.
EXAMINATION: The patient is a very pleasant gentleman who thinks he is funny. Higher functions are intact. Cranial nerves are normal. He sweats, according to him, equally on both sides both armpits. He does not have any difficulty with sweaty palms etc. Cranial nerves were intact. I did not even pick up a Horner's syndrome. No nystagmus. Upper extremities normal strength, normal tone, no drift. Repetitive movements were well done. Reflexes were equal though not as easily elicitable as they are but they are symmetrically very symmetric. Coordination was good. Trunk - other than a little generous midsection, the rest of him is okay, i.e. neck movements restricted because of surgery. Neck flexion is good. Neck extension is good. Thoracic kyphosis is maintained. Lumbar lordotic curve is straightened out. Gait is normal. He can walk on his heels. He can walk on his toes. Walking on his heels there seems to be slight care of the right foot i.e. left foot is kept higher than the right when he is walking. His Romberg was negative. Tandem was well done. He could squat and get up very easily without pain. He also could hop on each leg without any discomfort. He could touch his toes but lateral flexion was restricted to about 2 inches below knee. Back extensors are strong. Abdominal muscles were weaker as compared to the back extensors, i.e. he could not do a sit-up with his hips neutral, knees extended. He could pick his shoulders up maybe about 3-4 inches. Abdominal reflexes were normal. Cremasteric reflex was normal. Lower extremities were normal strength, normal tone, normal reflexes, normal sensation. Straight-leg raising test was unremarkable. Sacroiliac maneuvers unremarkable. Right piriformis maneuver was definitely positive and was different from the left side. Left side was nice and limber, on the right side it caused pain which he claimed to that this the kind of pain he had and also when forced the pain did try to go down in a sciatic distribution.
I have not reviewed his MRIs but he tells me that he was told that he has lumbar degenerative joint disease L4-L5 and L5-S1. Hemodynamically stable. Chest is clear. Skin is normal. Hair growth is normal. Nail growth is normal and he does not void himself and not know it and neither does he cut his nails short and not feel it.
IMPRESSION: Mechanical low back pain most likely piriformis mediated with some sciatic distribution status post cervical surgery mostly anterior approach. No evidence of myelopathy or radiculopathy.
RECOMMENDATIONS: I will let Dr. Geltner do piriformis injection under fluoroscopic screen and I will give him a physical therapy program which should consist of abdominal strengthening program and piriformis stretches. I would like to see him again in 1 month.
Vinod Sahgal, M.D.
VS/MedQ/290071

First Clinical Gateways

University Hospitals

JENNIFER KRINOV

ANDREW GREGOS Gender: M DOB: 1955-12-16 Age: 53
Phone: (330)393-3328 Address: 3076 CRESCENT DR NE WARREN OH 444836302

Result Detail

Outpatient Notes: Anesthesia

Exam Date: 05/11/2009 00:00:00 Report Date:
Accession Number: 371492681 Facility: UHCMC
Medical Record Number: 02819485 Ordering Provider:
Status: U Interpreting Physician:

UNIVERSITY HOSPITALS CASE MEDICAL CENTER
DIVISION OF PAIN MEDICINE

GREGOS, ANDREW
MRN: 02819485
DOB: 12/16/1955
DOS: 05/11/2009
LOCATION: Chagrin Highlands Clinic
CHIEF COMPLAINT: Low back pain.
HISTORY: This is a 53-year-old male with the above-noted pain for several years. He notes that he has had back pain ever since he has been a teenager, but over the past 4-6 years it has been considerably worse. He notes no specific identifying inciting event or injury. He describes the pain as dull, throbbing, stabbing, aching and hot. It is continuous and rates it anywhere from a 4-9/10; currently it is a 7/10. There is associated burning along the posterior right knee but no pain past the knee. He also gets occasional left posterior thigh burning as well. His pain is exacerbated with sitting for more than 20 minutes and standing for prolonged periods of time. His pain is relieved with lying flat, walking and physical therapy. Interventions include several epidural steroid injections performed in 2004 which were basically unhelpful; they provided him 1-2 days of mild relief. Medications such as Vicodin which he claims that he takes 1-1/2 pills at a time and he could take 1 pill every week and at times takes up to four doses in a day depending on the degree of his pain. He states that he has been evaluated for this low back pain in the past including a diagnostic diskography which was performed in 2005. At that time he states that it was thought to be the L3-4 and L4-5 levels that was contributing to his pain. Per the patient, he had been under consideration for disk replacement surgery back then but it was thought that multilevel disk replacement surgery was not an option for the patient. The patient was most recently evaluated by Dr. Hart on April 30, 2009, and subsequently referred here for interventional, diagnostic, and hopefully therapeutic treatments. He notes the pain to be disruptive to his sleep and physical activity.
MEDICATIONS: Clonidine, multivitamin, lisinopril, B12, vitamin C, Vytorin, Vicodin, aspirin.
ALLERGIES: He is allergic to Tolectin.
IMAGING STUDIES: An MRI of the lumbar spine was reviewed today which showed significant lumbar disk degeneration at the L3-4, L4-5, and L5-S1 levels, most significant at the L4-5 levels. There was mild disk bulging at the L4-5 and L5-S1 levels. There is also note of some facet hypertrophy in the lower lumbar spine bilaterally as well.
PAST MEDICAL HISTORY: Hypertension, hyperlipidemia.
PAST SURGICAL HISTORY: Cervical spine surgery, foot surgery, uvuloplasty, ACL repair on his left knee several months ago, appendectomy and vasectomy.
SOCIAL HISTORY: The patient is on sick leave from Delphi. He denies tobacco and illicit drug use. He drinks alcohol occasionally.
FAMILY HISTORY: Positive for heart disease.
REVIEW OF SYSTEMS: A 12 system review of systems is negative throughout except for those symptoms mentioned in the HPI.
PHYSICAL EXAM: No acute distress, alert and oriented x3. The patient was accompanied by his wife the entire visit. He declined additional

chaperone. Head and Neck Evaluation: Cranial nerves II-XII are grossly intact. Cervicothoracic spine range of motion is within normal limits. Upper extremity evaluation reveals 5/5 strength bilaterally. Abdomen: Soft, nontender. Lumbar spine is very mildly tender in the lumbar paraspinal muscles. There is no obvious scoliosis, scars, kyphosis or vertebral tenderness. Range of motion of his lumbar spine is decreased in both flexion and extension. Facet loading was mildly positive bilateral lower lumbar spine. There is no obvious atrophy or asymmetry in the paravertebral, quadratus lumborum, piriformis or gluteal musculatures. Sacroiliac joints were nontender to palpation. Patrick's test was negative bilaterally. Lower extremity evaluation reveals a negative straight leg raise test bilaterally. Temperature is equal. Sensation is intact. Reflexes are equal. Heel and toe walking are able to be performed and pulses are palpable. Motor exam reveals 5/5 strength throughout bilateral lower extremities.

ASSESSMENT: This is a 53-year-old male who based on his history, physical exam and imaging studies is suffering from lumbar degenerative disk disease, possible discogenic pain as well as lumbar spondylosis with a facet component to his pain.

PLAN: I suggested to the patient as a first step in the diagnostic process that he undergo a series of diagnostic facet medial branch blocks under fluoroscopic guidance. This would be done with just local anesthetic at the bilateral L2-3, L3-4, and L4-5 levels. A detailed description of the procedure including risks, benefits, and alternatives were discussed with the patient. I discussed with him that it would be necessary for him to come into the procedure with his typical pain. Therefore he should not take his pain medications that day or probably the day before as well. If he does get very good relief for the duration of the local anesthetic, a repeat of the injection would be in order. If again he gets very good relief, radiofrequency ablation may be helpful for this patient. On the other hand, if the patient does not get relief from the facet medial branch blocks we will move to diagnostic diskography to interrogate the L3-4, L4-5 and L5-S1 disks using the L2-3 disk as a control. I did discuss with the patient the risks, benefits and alternatives to both the facet medial branch blocks as well as diskography. He and his wife were both in complete agreement as to the proposed plan. They were invited to call the clinic with any questions or concerns. Thank you very much for this referral.

Joshua Goldner, M.D.
JG/MedQ/801347
cc: David J. Hart, M.D.

University Hospitals

JENNIFER KRINOV

ANDREW GREGOS **Gender:** M **DOB:** 1955-12-16 **Age:** 53
Phone: (330)393-3328 **Address:** 3076 CRESCENT DR NE WARREN OH 444836302

Result Detail

Operative Reports and Procedures: Operative Reports

Exam Date: 06/30/2009 00:00:00 **Report Date:**
Accession Number: 28000757 **Facility:** UHCMC
Medical Record Number: 02819485 **Ordering Provider:** Goldner Joshua
Status: F **Interpreting Physician:** JOSHUA D GOLDNER

University Hospitals
Case Medical Center
11100 Euclid Avenue
Cleveland, OH 44106
Patient Name: GREGOS, ANDREW
MRN: 2819485
DOB: 12/16/1955
Encounter Number: 23515287
Date of Service: 06/30/2009
Patient Location: TASA TASA0 TASA013
Patient Type: O
Surgeon: Joshua David Goldner MD
Report Type: Operative Reports
PREOPERATIVE DIAGNOSIS:
721.3 lumbar spondylosis without myelopathy, 722.52 degenerative disk disease of lumbar spine, 724.2 lumbago.
POSTOPERATIVE DIAGNOSIS:
721.3 lumbar spondylosis without myelopathy, 722.52 degenerative disk disease of lumbar spine, 724.2 lumbago.
OPERATION/PROCEDURE:
L2-L3, L3-L4, L4-L5 provocative diskography with fluoroscopic guidance.
SURGEON:
Joshua David Goldner, MD
ASSISTANT(S):
Tiffany H Selong, DO, pain fellow.
ANESTHESIA:
2 mg IV midazolam for mild sedation and local anesthesia.
REFERRING PHYSICIAN:
David Joseph Hart, MD
LOCATION:
Mather Outpatient Surgery Center.
START TIME:
11:30.
STOP TIME:
12:15.
COMPLICATIONS:
None apparent.
INDICATIONS FOR PROCEDURE:
This is a 53-year-old gentleman with several years of low back pain who has previously been evaluated by Dr. David Joseph Hart. He has had a previous diskography with apparent concordant pain at L3/L4 and L4/L5. His pain is low back with some posterior radiating thigh pain. He has an MRI evidence of degenerative disk disease from L3/L4 through L5/S1. He has further degeneration at L4/L5 and L5/S1 disks. Our plan is to do diskography for levels L2/L3 through L5/S1 with L2/L3 being the control.
PROCEDURE NOTE:
The patient was identified in the preoperative holding area. Written informed consent was obtained. An IV cannula was placed. Two g of IV Ancef was administered. The patient was taken to the operating room and placed prone on the fluoroscopic table. Low back was sterilely prepped and draped in the usual fashion. The skin and subcutaneous tissues overlying the planned needle

trajectories were anesthetized with 5 mL of 0.5% lidocaine at each level. A 16-gauge Angiocath was advanced toward the appropriate disk space in coaxial view. Next, a 22-gauge Chiba needle was advanced under intermittent fluoroscopic guidance to the central portion of the disk at L2/L3, L3/L4, and L4/L5. An attempt was made to pass the Chiba needle into the L5/S1 disk, but the superior articular process was obstructing the entry, and the disk was unable to be entered, so it was abandoned at L5/S1. Next, using pressure measured diskography, the L4/L5 disk showed pain that increased from 5/10 to approximately 7/10, but the pain was in his low back without any radiating symptoms, and this was not concordant with his usual pain pattern. The identical reaction occurred at L3/L4. The disk pressures were achieved after 70 psi, and the volume injected was up to 4 mL at both levels. This was considered negative diskography because the pain was not concordant. The spread of contrast in the disk showed degenerative disk with annular tears and fissures throughout. At the L2/L3 level, the patient did not complain of any pain with pressures of up to 70 psi. There was good bilobar spread to the disk material with no evidence of fissure or tear. This was a negative diskography at this level as well. At the end of the procedure, each needle was injected with 1 mL of solution that was originally prepared with 0.75% bupivacaine, 20 mg triamcinolone, and 100 mg Ancef. This was equally divided between the 3 needles. The patient tolerated the procedure well and will be discharged with 20 tablets of Percocet for in case his pain has flared after this procedure. He should follow up in the clinic for further treatment options, and he can also follow up with Dr. David Joseph Hart.

Tiffany H Selong, MD
DD: 06/30/2009 13:23 EST
TT: 07/01/2009 08:49 AM EST
DICTATION NUMBER: 45644
SPHERIS JOB NUMBER: 28000757
CC:
Joshua Goldner MD, 2168442660
David Hart MD, 2168443014
Dr. Justin Mikula
Electronically Signed by Dr. Joshua Goldner 07/22/2009 11:02:30 AM

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

PATIENT'S NAME: ANDREW C GREGOS Claim #: 980710010278

The patient is responsible for the completion of the form without expense to the Insurance Company.

1. Present Condition:

(a) Patient is: Ambulatory (✓) Bed confined ( ) House Confined ( ) Hospital confined ( )

(b) Patient's symptoms: persistent neck & back pain

(c) Objective findings (include results of current X-rays, E.K.G's or any other special tests)

see attached consult letter

(d) Diagnosis: Lumbago, chronic pain syndrome

2. Treatment:

(a) Date of first visit: 8-14-2008 (b) Date of last visit 9-19-2008

(c) Frequency of visits: Weekly ( ) Monthly ( ) Other Q6months

(d) When did you last examine patient? 9-19-2008

3. Prognosis: Recovered ( ) Improved ( ) Unimproved (✓) Retrogressed ( )

4. Extent of Disability:	**For Any Occupation**	**For Employee's Regular Occupation**
(a) Is patient now totally disabled?	Yes (✓) No ( )	Yes (✓) No ( )
(b) If yes, when do you think patient will be able to resume any work?		
Approximate Date...	Mo ____ Day ____ Year ____	Mo ____ Day ____ Year ____
Never ..... (✓)		
(c) If no, when was patient able to go to work?		
	Mo ____ Day ____ Year ____	Mo ____ Day ____ Year ____
(d) Is the patient able to perform restricted work?	Yes ( ) No (✓)	

Restrictions:

(e) Is the patient suitable for a rehabilitation program? Yes ( ) No (✓)

5. Mental Condition: Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes (✓) No (

6. Remarks: See attached consult letter. I have not personally performed functional capacity assessment on this patient. Level of pain has remained unchanged and no evidence of

Physician's name (please type or print) Justin P. Makley, M.D.

Office address 1615 North River Rd NE, Warren, OH 44483

Specialty Board Certification Internal medicine Phone No. (330) 372-2333

Date Completed 12-3-08 Physician's signature

CENTRAL OHIO NEUROLOGICAL SURGEONS

David Yashon, M.D., F.A.C.S. F.R.C.S.(C.) – 614-224-1720
Edward Sadar, M.D., F.A.C.S. – EMERITUS
Thomas Hawk, M.D., F.A.C.S. – EMERITUS
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Gregory Baltushot, M.D.- 614-261-0073
William R. Kemp, M.D., F.A.C.S.- 614-261-0456
James Uselman, M.D., F.A.C.S.- 614-261-0048
Kelly J. Kiehm, M.D. – 614-261-0082
John Ogden, M.D. - 614-545-4330
Mark Hnilica, M.D.-614-268-5655

October 7, 2008

Justin Mikula, M.D.
1615 North River Road NE
Warren, OH 44483

RE: Andrew Gregos
DOB: 12-16-1955

Dear Dr. Mikula:

Andrew Gregos returned to see me today. As you know, I have seen him previously for his neck and low back. He continues to describe a lot of pain in his neck, as well as a weakness feeling in his right arm and not having normal motion of his right arm when he walks. He also describes a lot of pain in his back. He does not sleep well. He has to sleep on the floor basically. He spends a lot of time in bed, but he forces himself to function.

We had talked about his numbness in his hands, which I felt may well be carpal tunnel syndrome.

NEUROLOGICAL EXAMINATION: On exam, he has 5/5 strength in his deltoids, biceps, triceps, finger intrinsics, grip, hip flexors, knee extensors, foot dorsiflexion and plantar flexion. He has a negative Hoffmann and negative clonus.

DATA REVIEWED: I reviewed his MRI's and he has a broad-based disc osteophyte complex at L3-4 and L4-5 and facet arthropathy at these two levels, but there are also degenerative changes at L5-S1. There is no stenosis or protrusion at L1-2 and 2-3. These levels are relatively well preserved comparatively.

In terms of his neck, there is a postoperative fusion at C5-6 and C6-7, degenerative disc bulge at C7-T1 and mild disc bulging at T1-T2. There is no significant central spinal stenosis.

TREATMENT OPTIONS AND PLAN: I do not think his changes are surgical. We talked about things like artificial disc replacement, traction, acupuncture, other types of management, exercise and traction.

At this point, he does not feel he is able to perform his job and I would concur that, since he really spends a large part of the time in the recumbent position because of his severe pain, he would not be able to perform his job duties.

Thank you for allowing me to participate in the care of your patient.

Sincerely,

Bradford B. Mullin, M.D., F.A.C.S.
Director, Division of Neurosurgery MCE

BBM/dm
Dictated but not read by the doctor.

McKESSON
Empowering Healthcare

Name: **Gregos, Andrew**
DOB: **12-16-55**
ID: **00060340**
Study Date: **09-23-08**

History- Chronic pain, radiculopathy.
""

Findings-
""

Sagittal and axial images of the lumbar spine were obtained using multiple pulsing sequences. There is normal alignment of the lumbar spine. There is no acute compression fracture. There is loss of normal T2 signal intensity within the L3-L4, L4-L5 and L5-S1 discs, consistent with disc desiccation. Degenerative endplate changes are noted at the L4-L5 level. There is significant disc space height loss at the L4-L5 level.
""

The conus medullaris is noted at the L1 level.
""

L1-L2 and L2-L3- There is no focal disc protrusion, central canal stenosis or neuroforaminal narrowing.
""

L3-L4- There is a broad-based disc bulge as well as posterior degenerative endplate spurs. Facet arthropathy and ligamentum flavum hypertrophy is noted. This combination causes mild central canal stenosis. There is mild to moderate bilateral foraminal stenosis.
""

L4-L5- There is a broad-based disc bulge with a small central disc extrusion. Degenerative endplate spurs are noted at this level. There is facet arthropathy. The combination causes mild central canal stenosis and mild to moderate neuroforaminal narrowing.
""

L5-S1- There is a small broad-based disc bulge. There is no disc herniation. There is no central canal stenosis or neuroforaminal narrowing. There is facet arthropathy.
""

Impression-
1. Broad-based disc and osteophyte complexes at the L3-L4 and L4-L5 levels. There is also facet arthropathy at these 2 levels. The combination causes mild central canal stenosis at both levels. There is mild to moderate bilateral foraminal narrowing at both of these levels.

Transcriptionist- DH
Read By- PAUL N GOULD M.D.
Released By- PAUL N GOULD M.D.

McKESSON
Empowering Healthcare

Name: **Gregos, Andrev**
DOB: **12-16-55**
ID: **00060340**
Study Date: **09-23-08**

clinical statement- Neck pain into right arm
""

findings- Multiplanar imaging with multiple sequences obtained. Comparison with 5/30/2006. straightening of the normal cervical curve is again noted. Anterior fusion involving C5-C6 and C6 several levels are again noted. Disc space loss is again seen at C7-T1. at C2-C3 and C3-C4 there is no evidence for herniation or central stenosis. At C4-C5 there is mild bulging disc seen centrally. No gross herniation or spinal stenosis seen. At C5-C6 there is no evidence for herniation or central stenosis. At C6-C7 there is also no evidence for herniation or central stenosis. C7-T1 minimal bulging disc is seen without gross change. A T-1/2 mild bulging disc also seen. Narrowing of the neuroforamina seen bilaterally at C3-C4.
""

impression- Postoperative anterior cervical fusion at C5-C6 and C6-C7 without gross change. Degenerated bulging disc at C7-T1 is again noted. Mild bulging disc at T1-T2 is seen. Mild central bulging disc at C4-C5. No significant central spinal stenosis or cord compression seen.
""
""
""

Transcriptionist- HSA M.D.
Read By- HOWARD S AMES M.D.
Released By- HOWARD S AMES M.D.
Released Date Time- 09/23/08 1629

Signed by: Signed at:

Date _____

[redacted]

YOU HAVE BEEN SCHEDULED FOR A MEDICAL EXAMINATION ON:

Date _____

Time _____ ☐ A.M. ☐ P.M. WITH:

[redacted]

Examining Physician/Clinic:

To:

A provision of the Life and Disability Benefits Program permits a medical examination with respect to your eligibility to receive Sickness and Accident or Extended Disability Benefits. The Corporation and the Union have agreed that required examinations of employees are to be performed by a clinic and/or doctors selected from a list of Impartial Medical Examiners.

Please report to the Examining Physician/Clinic named at the top of this letter on the date and time indicated. To assist the examiner in his/her evaluation, and to avoid duplicate testing, if possible, please bring with you your medical records, any test results, x-rays, and/or a list of medications you are currently taking. **You will not be required to pay any fee for the examination. In accordance with an agreement between the Corporation and the Union, the Impartial Medical Examiner's determination will be final and binding upon you, the Corporation, the Union, and MetLife with respect to your current claim for disability benefits. Failure to report for this examination may result in the denial of Sickness and Accident or Extended Disability Benefits.**

If you returned to work on the date of the examination, it will not be necessary for you to report for the examination. However, if you again become disabled prior to the time of the examination, you should immediately contact the National Benefit Center.

You should obtain the results of your examination by calling the number shown below on the date of the examination.

Restriction Form

DELPHI NATIONAL BENEFIT CENTER
INTEGRATED DISABILITY ACTIVITY
P.O. BOX 14608
LEXINGTON, KY. 40511-4608
FAX # 1-908-552-3181

TO: Dr. Fatmire (Mily) Zhubi, **MEDICAL REVIEWER-TEAM 11**
RE: **Andrew C Gregos** METLIFE/DELPHI CL.# **420609208052**
D.O.B 12/16/55 CISCO: **55905**

Thank you for providing the information requested below. I will forward this information to the Delphi Plant where the employee works. The Delphi Plant will contact the employee when a job within your restrictions is found, if no job is available within your restrictions the employee will continue to receive Disability Benefits.

1. Is employee eligible to return to work with restrictive duty? ____yes / X no

2. Employee released to return to work on _____with the following restrictions:

A. One handed position_____.

B. Sit down position _____% of the time.

C. Limit lifting, carrying,pushing, and pulling to _____lbs.

D. No climbing _____.

E. No repetitive bending_____.

F. Other_____

_____

_____

These restrictions are to be in effect from _____through_____.

3. If the employee is not eligible to return to a restricted job, please supply the following information:

a. Medical update: PT must be in Supine position 50% of Time -

b. Date of last office visit: 2-8-07 c. Date of next office visit 1 month

[signature] Physician's signature 2-8-07 Date

~~Dr. Jagdish Patel, 330/856-7822~~
EA Dechellis DO
330 637-4000

[redacted]

Date of this letter 4/3/09

YOU WERE EXAMINED ON:

Date _____

Time _____ ☐ A.M. ☐ P.M. WITH:

[redacted]

Examining Physician/Clinic:

To:

☒ The Impartial Medical Examiner, named above, indicated you were found to be unable to work at the t of the above examination.

☐ The Impartial Medical Examiner, named above, indicated you were found to be unable to work at the t of the above examination. According to the most recent medical information received from your physic you will be able to return to work on or before _____ . Theref Sickness and Accident or Extended Disability Benefits will continue through _____ (However, if you are scheduled for a medical examination prior to this date, benefits may be suspen sooner, depending on the results of the examination.)

☐ The Impartial Medical Examiner, named above, indicated you were found to be able to work at the tim the above examination. The results of this examination are final and binding upon you, the Corporation, Union and the Insurance Company. Generally, benefits are not payable after you have been found tc able to work. Accordingly, your claim is being reviewed and you will be notified in writing of our decisic

☐ The Impartial Medical Examiner, named above, indicated you were found to be able to work at the tim the above examination. The results of this examination are final and binding upon you, the Corporation, Union and the Insurance Company. Generally, benefits are not payable after you have been found tc able to work. Accordingly, your claim is being reviewed and you will be notified in writing of our decisic Meanwhile, you will receive a check for benefits through _____

If you have any questions regarding your claim or this examination, contact the National Benefit Center.

FOR REPRESENTED EMPLOYEES:

IMPARTIAL MEDICAL OPINION/METROPOLITAN MEDICAL EXAMINER'S PROGRAM

Authorization to Release Medical Examiner's Report

IF YOU DESIRE A COPY OF THE EXAMINATION REPORT TO BE RELEASED TO YOUR UNION, PLE/ SIGN AND DATE THE FOLLOWING RELEASE AND RETURN IT TO THE NATIONAL BENEFIT CENTE

I acknowledge that the Impartial Medical Examiner's/Metropolitan Medical Examiner's report including psychiatric and psychological information or tests and the opinion of the Impartial Medical Exami Metropolitan Medical Examiner with whom I have been scheduled for an impartial medical examinatio Metropolitan medical examination on (Date) _____ , will be released to the Corpora MetLife and their designated representatives.

I hereby consent to the release of the same material and opinion to my Union Benefit Representative.

Date _____ Signature _____

CENTRAL OHIO NEUROLOGICAL SURGEONS

DAVID YASHON, M.D., F.A.C.S., F.R.C.S. (C.) - 224-1720
EDWARD S. SADAR, M.D., F.A.C.S. - EMERITUS
THOMAS HAWK, M.D., F.A.C.S. - EMERITUS
BRADFORD B. MULLIN, M.D., F.A.C.S. - 868-5872
WILLIAM R. ZERICK, M.D. - 268-0105
MARK A. FULTON, M.D. - 268-5531
CAROLYN S. NELTNER, M.D. - 868-9849
ROBERT J. GEWIRTZ, M.D., F.A.C.S. - 261-0393
CHRISTIAN L. BONASSO, M.D. - 263-7002
GREGORY W. BALTURSHOT, M.D. - 261-0073
WILLIAM R. KEMP, M.D., F.A.C.S. - 261-0456
JAMES H. USELMAN, M.D., F.A.C.S. - 261-0048
KELLY KIEHM, M.D. - 261-0082

January 18, 2007

Jagdish Patel, M.D.
1930 Nile Courtland Rd.
Warren, OH 44484

Dear Dr. Patel: **RE: Andrew C. Gregos (DOB: 12-16-55)**

Andrew Gregos returned to see me today in consultation. We discussed his back and he's still having a lot of difficulty. He really cannot sit for any length of time at all. If he does so it gives him quite severe pain. He spends about 25-50% of his time laying down. He also states if he stands for any length of time he has severe pain so basically he cannot sit or stand for any length of time. We also talked about his arm. He does still have some T1 related symptomatology, but I can't find a lesion that fits with it.

NEUROLOGICAL EXAM: His blood pressure is 143/86, pulse is 69, temperature is 97.6, height is 6'1", and weight is 211 lbs. General Appearance: he's in no apparent distress. His station and gait are within normal limits. He is awake and oriented. Memory is intact, attention is within normal limits, speech is within normal limits, and knowledge is adequate.

DATA REVIEWED: He has no new test findings.

TREATMENT OPTIONS: We discussed a three level disc surgery and I do not feel it is indicated at this time because the disc is only approved for single level placement. Regarding his arm difficulties I told him a myelogram would be necessary if we need to look at this further. I also talked to him about and offered him a carpal tunnel release. We discussed a carpal tunnel release and I explained the risks to include, but not be limited to weakness, numbness, paresis, and a very small possibility of reflex sympathetic dystrophy. At this point we're waiting to hear back from him further.

Sincerely,

Bradford B. Mullin, M.D., F.A.C.S.
Director Division of Neurosurgery MCE
Mount Carmel East Medical Building
BBM/dm
Dictated but not proofread by Dr. Mullin.
D: 01-18-07
T: 01-23-07

cc: Andrew C. Gregos

CENTRAL OHIO NEUROLOGICAL SURGEONS

DAVID YASHON, M.D., F.A.C.S., F.R.C.S. (C.) - 224-1720
EDWARD S. SADAR, M.D., F.A.C.S. - EMERITUS
THOMAS HAWK, M.D., F.A.C.S. - EMERITUS
BRADFORD B. MULLIN, M.D., F.A.C.S. - 868-5872
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WILLIAM R. KEMP, M.D., F.A.C.S. - 261-0456
JAMES H. USELMAN, M.D., F.A.C.S. - 261-0048

July 18, 2006

Jagdish Patel, M.D.
1930 Nile Courtland Rd.
Warren, OH 44484

Dear Dr. Patel: **RE: Andrew C. Gregos (DOB: 12-16-55)**

Andrew Gregos returned to see me today in consultation. We discussed several issues.

NEUROLOGICAL EXAM: His blood pressure is 132/84 , pulse is 63, temperature is 97.3, height is 6'1'', and weight is 218 lbs.

DATA REVIEWED: He has T1 root changes. His MRI did not really show a clear lesion other than the bulge at C7-T1. That could effect the level below. On theses studies the radiologist does not describe anything below that level.

TREATMENT OPTIONS: I'm referring him for physical therapy on that. In terms of his hands he does have carpal tunnel. When he's not working they are better. At this point we're going to hold off on surgery, although I did describe a carpal tunnel release. We discussed a carpal tunnel release and I explained the risks to include, but not be limited to, weakness, numbness, paresis, and a very small possibility of reflex sympathetic dystrophy. In terms of his low back I feel he would benefit from further therapy on his low back. He likely needs to progress toward considering disability at work. He really is getting to the point that he cannot function at work with the type of work he does. I told him I support that, although I do not perform disability examinations. I can offer the documentation I have already in his chart as evidence of the disease process in his low back.

Sincerely,

Bradford B. Mullin, M.D., F.A.C.S.
Director Division of Neurosurgery MCE
Mt. Carmel East Medical Building
BBM / dm
Dictated but not proofread by Dr. Mullin.
D: 07-18-06
T: 07-24-06

cc: Andrew C. Gregos

Eschman
PHYSICAL THERAPY, LLC
Delivering gentle pain relieving care.

2581 North Road N.E., Suite A, Warren, OH 44483 PH#: 330-372-5800 FAX#: 330-372-5841

October 18, 2006

Bradford B. Mullen, M. D., F. A. C. S.
5985 E. Broad St., Suite 420
Columbus, OH 43213

Re: **Andrew Gregos, DOB: 12-16-55 / Reassessment**
Diagnosis: Cervical HNP (722.0), Degeneration of Lumbar Intervertebral Disc (722.52)

Dear Dr. Mullen,

Your patient Andrew Gregos was reassessed today after 11 visits with the following findings:

Subjective Complaints:

Chief Complaint: The patient's primary complaint continues to be right-sided low back pain, which radiates down into his right buttock and hip area. The patient now rates the pain on the visual analogue scale as a 4 or 5 compared to in initial level of 9 out of 10. The patient describes the pain as a constant sharp pain. The patient now utilizes the Oswestry pain index to indicate that the pain is moderate compared to in initial level of fairly severe. Aggravating factors include primarily sitting, while relieving factors include lying down with his feet elevated. The patient reports that his sleep is disturbed and that he feels his condition is worsening.

Objective Measurements:

General Observations and Comments: Observations of the patient's posture shows no significant postural faults other than the fact that the patient has a relatively flattened lumbar lordosis. The patient now rates his pain on the Oswestry pain index as 22 out of 100 points compared to in initial level of 28 out of 100 points.

Active / Passive Range of Motion:

Left Lower Extremity: Within functional limits for hip and knee extension, and flexion and hip abduction. Straight leg raising is now measured as 118° to 122° compared to in initial level of 87° to 93°.
Right Lower Extremity: Within functional limits for hip and knee extension, flexion and hip abduction. Straight leg raising is now measured as 104° to 114° compared to in initial level of 89° to 96°.
Thoracolumbar: Flexion at T12 now ranges from 115° to 119° compared to in initial level of 61° to 73°, whereas sacral flexion is now from 65° to 72° compared to in initial level of 30° to 39°. Extension at T12 is now measured at 46° to 48° compared to in initial level of 30° to 33°, whereas extension of the sacrum now measures from 18° to 22° compared to in initial level of 13° to 14°. Left lateral flexion at T12 now ranges from 21° to 27° compared to in initial level of 14° to 16°, whereas at the sacrum now ranges from 7° to 9° compared to in initial level of 1° to 2°. Right lateral flexion at T12 now ranges from 20° to 22° compared to in initial level of 18° to 19°, whereas at the sacrum now ranges from 7° to 12° compared to in initial level of 5° to 6°.

Manual Muscle Testing:

Left Lower Extremity: Continues to be graded as 5/5 regarding hip and knee flexion and extension and hip abduction.
Right Lower Extremity: Continues to be graded as 5/5 for hip and knee flexion, extension and hip abduction.
Left Upper Extremity: Grip strength now ranges from 112 to 125 pounds compared to in initial level of 109 to 126 pounds.
Right Upper Extremity: Grip strength now ranges from 119 to 130 pounds compared to in initial level of 92 pounds to 112 pounds
Lumbar: Extension is approximately 16 pounds, whereas flexion is approximately 12 pounds.

Muscle Endurance: Very good.
Joint Examination: SI compression and distraction testing produces no significant increases in the patient's pain. Application of passive intervertebral movements does reproduce pain, especially in the lower lumbar region.

Letter To: Dr. Bradford Mullen
RE: Andrew Gregos
Dated: 10-18-06
Page II of II

Palpation Examination: Fascial mobility in the thoracolumbar region is somewhat restricted however; the patient reports no pain with application of cross hand release techniques or during fascial mobility testing.
Gait Analysis: Unremarkable, the patient's primary complaint is of pain with a seated position.

Assessment: The patient's major limiting problem continues to be his complaint of pain in the right side of the low back radiating down into the right buttock. The patient now rates the pain on the visual analogue scale as a 4 or 5 out of 10 compared to in initial level of 9 out of 10. The patient now utilizes the Oswestry pain index to classify the pain as a moderate pain compared to in initial level of fairly severe pain, and scores the pain as 22 out of 100 points compared to in initial level of 28 out of 100 points. The range of motion analysis now shows that the patient has improved with regard to flexion at T12 and the sacrum. The patient is hypermobile with regard to extension at T12 and the sacrum. This would seem to indicate that lumbosacral stabilization exercises may be indicated and may be helpful. Side bending at T12 and at the sacrum is slightly hypomobile however; the patient does report an increase in pain with right side bending activities. Obviously the patient will be cautioned to avoid such activities. Muscle testing shows that lower extremity strength is at least good if not normal, with regard to hip, knee and ankle strength. Trunk strength also appears to be good however; treatment will focus on the lumbosacral stabilization exercises to provide stability to this extremely mobile area. Palpation of the thoracolumbar spine shows that the fascia appears to be slightly restricted with regard to a posterior glide of the tissue. Based on the patient's diagnosis and the results of the evaluation today the prognosis for rehabilitation is good based on the plan of care and goals below.

Plan of Care: The patient will continue to be seen 2 to 3 times per week for 4 weeks for a physical therapy treatment program to consist of the following:

1. Modalities for relief of pain. Modalities to include Lordex Lumbar Decompression System for mechanical traction, or ultrasound, as needed.
2. Therapeutic procedures, such as therapeutic exercise, including use of the Lordex Rx1 for thoracolumbar strengthening, neuromuscular re-education, gait training, manual therapy techniques for soft tissue and joint mobilization or manual traction. Therapeutic procedures may also include therapeutic activities or self care and home training.

Short-Term Goals: (over the course of the next 3 weeks):
1. Continue to decrease the patient's subjective complaint of pain 1-2 levels on the visual analogue scale.
2. Continue to decrease the patient's score on the Oswestry pain index by 5-10 points.
3. Continue to increase the patient's fascial mobility 1/2 to 1 grade.
4. Continue to increased stability and strength of the lumbosacral spine to prevent excessive mobility in the lumbosacral spine.
5. Continue to increase the patient's ability to sit for longer than 60 minutes without extreme pain.
6. Continue to increase the patient's ability to be up on his feet for longer than 60 minutes without extreme pain.
7. Continue to increase the patient's ability to sleep for greater than 6 hours without extreme pain.

Long-Term Goals: (over the course of the next 4 weeks):
1. Return the patient to his previous level of functional mobility without pain.
2. Restore the patient's ability to perform activities of daily living without pain.
3. Enable the patient to sit for least 60 minutes without extreme pain

Thank you for the referral and the opportunity to work with Mr. Andrew Gregos at Eschman Physical Therapy, LLC. If you have any questions or comments, please feel free to contact me at 330-372-5800.

Sincerely,

Joseph M. Eschman P.T., G.C.S.
Physical Therapist, Geriatric Certified Specialist

Scoring: Oswestry

Simply count up all the points and divide 50 (or 45 if they leave out one section) and multiply by 100 to get your score.

Example: on my last ODI I scored a 16. So, 16/50 x 100 = 32% disability:

Categories:

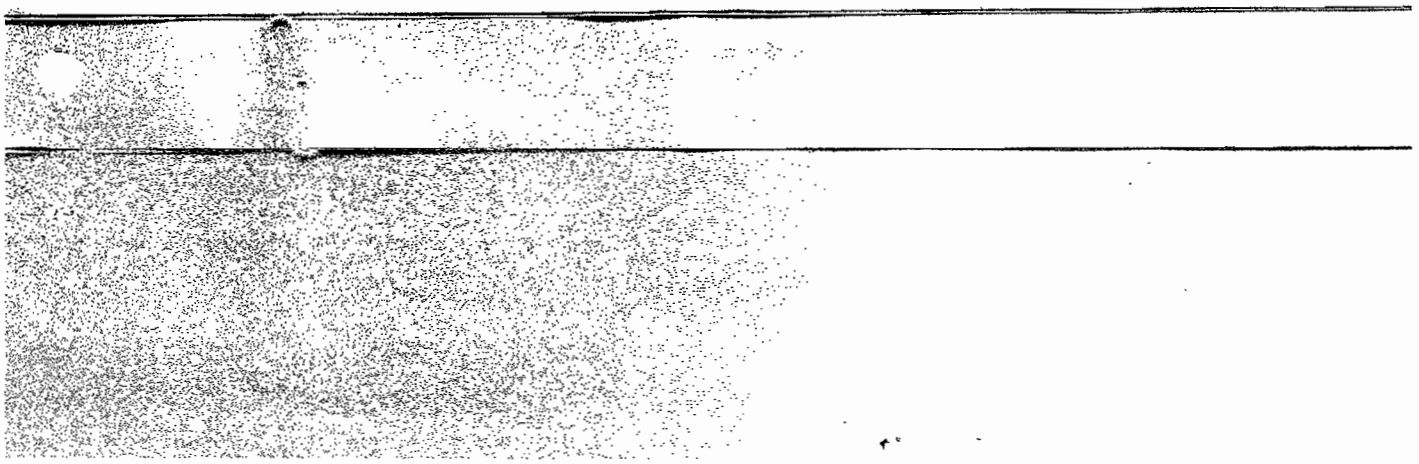
0% to 20%: minimal disability: The patient can cope with most living activities. Usually no treatment is indicated apart from advice on lifting sitting and exercise.

21%-40%: moderate disability: The patient experiences more pain and difficulty with sitting lifting and standing. Travel and social life are more difficult and they may be disabled from work. Personal care sexual activity and sleeping are not grossly affected and the patient can usually be managed by conservative means.

41%-60%: severe disability: Pain remains the main problem in this group but activities of daily living are affected. These patients require a detailed investigation.

61%-80%: crippled: Back pain impinges on all aspects of the patient's life. Positive intervention is required.

81%-100%: These patients are either bed-bound or exaggerating their symptoms.



COPY

Eschman
PHYSICAL THERAPY, LLC
Delivering gentle pain relieving care.
2581 North Road N.E., Suite A, Warren, OH 44483 PH#: 330-372-5800 FAX#: 330-372-5841

September 25, 2006

Bradford B. Mullen, M. D., F. A. C. S.
5965 E. Broad St., Suite 420
Columbus, OH 43213

Re: **Andrew Gregos, DOB: 12-16-55 / Initial Evaluation**
Diagnosis: Cervical HNP (722.0), Degeneration of Lumbar Intervertebral Disc (722.52)

Dear Dr. Mullen,

Your patient Andrew Gregos was evaluated today with the following findings:

Subjective Complaints:

Chief Complaint: The patient's primary complaint is of right-sided low back pain, which radiates down into his right buttock and hip area. The patient rates the pain on the visual analogue scale as a 9 out of 10. The patient describes the pain as a constant sharp pain. The patient utilizes the Oswestry pain index to indicate that the pain is fairly severe. Aggravating factors include primarily sitting, while relieving factors include lying down with his feet elevated. The patient reports that his sleep is disturbed and that he feels his condition is worsening.
Past Medical History: Hypertension.
Past Surgical History: Cervical fusion January of 2004, foot surgery 1985 and 1987, appendectomy 1978, eye surgery 1963.
Medications: Clonidine, Lisinopril, Vytorin, Hydrocodone
Patient's Goals: The patient's goals for therapy are to be able to sit for longer than 30 minutes without severe pain or sleep for longer than 6 hours without pain. The patient also reports he would like to be able to stand or be up on his feet for longer than 30 to 60 minutes without severe pain.

Objective Measurements:

General Observations and Comments: Observations of the patient's posture shows no significant postural faults other than the fact that the patient has a relatively flattened lumbar lordosis. The patient rates his pain on the Oswestry pain index as 28 /100 points.

Active / Passive Range of Motion:

Left Lower Extremity: Within functional limits for hip and knee extension, and flexion and hip abduction. Straight leg raising is measured as 87° to 93°.
Right Lower Extremity: Within functional limits for hip and knee extension, flexion and hip abduction. Straight leg raising is measured as 89° to 96°.
Thoracolumbar: Flexion at T12 now ranges from 61° to 73°, whereas sacral flexion is from 30° to 39°. Extension at T12 is measured at 30° to 33°, whereas extension of the sacrum measures from 13° to 14°. Left lateral flexion at T12 ranges from 14° to 16°, whereas at the sacrum it ranges from 1° to 2°. Right lateral flexion at T12 ranges from 18° to 19°, whereas at the sacrum ranges from 5° to 6°.

Manual Muscle Testing:

Left Lower Extremity: 5/5 regarding hip and knee flexion and extension and hip abduction.
Right Lower Extremity: 5/5 for hip and knee flexion, extension and hip abduction.
Left Upper Extremity: Grip strength ranges from 109 to 126 pounds.
Right Upper Extremity: Grip strength ranges from 92 pounds to 112 pounds
Lumbar: Extension is approximately 16 pounds, whereas flexion is approximately 12 pounds.
Muscle Endurance: Very good.
Joint Examination: SI compression and distraction testing produces no significant increases in the patient's pain. Application of passive intervertebral movements does reproduce pain, especially in the lower lumbar region.

Letter To: Dr. Bradford Mullen
RE: Andrew Gregos
Dated: 09-25-06
Page II of II

Palpation Examination: Fascial mobility in the thoracolumbar region is somewhat restricted however; the patient report: no pain with application of cross hand release techniques or during fascial mobility testing.
Gait Analysis: Unremarkable, the patient's primary complaint is of pain with a seated position.

Assessment: The patient's major limiting problem is his complaint of pain in the right side of the low back radiating down into the right buttock. The patient rates the pain on the visual analogue scale as a 9 out of 10. The patient utilized the Oswestry pain index to classify the pain as a fairly severe pain, and scores the pain as 28 out of 100 points. This score on the Oswestry indicates that the patient has a moderate disability. The range of motion analysis shows that the patient is limited with regard to flexion at T12 and the sacrum. The patient is hypermobile with regard to extension at T12 and the sacrum. This would seem to indicate that lumbosacral stabilization exercises may be indicated and may be helpful. Side bending at T12 and at the sacrum is slightly hypomobile however; the patient does report an increase in pain with right side bending activities. Obviously the patient will be cautioned to avoid such activities. Muscle testing shows that lower extremity strength is at least good if not normal, with regard to hip, knee and ankle strength. Trunk strength also appears to be good however; treatment will focus on the lumbosacral stabilization exercises to provide stability to this extremely mobile area. Palpation of the thoracolumbar spine shows that the fascia appears to be slightly restricted with regard to a posterior glide of the tissue. Based on the patient's diagnosis and the results of the evaluation today the prognosis for rehabilitation is good based on the plan of care and goals below.

Plan of Care: The patient will be seen as prescribed 2 to 3 times per week for 4 weeks for a physical therapy treatment program to consist of the following:

1. Modalities for relief of pain. Modalities to include Lordex Lumbar Decompression System for mechanical traction, electrical stimulation, including a home tens unit, or ultrasound, as needed.
2. Therapeutic procedures, such as therapeutic exercise, including use of the Lordex Rx1 for thoracolumbar strengthening, neuromuscular re-education, gait training, manual therapy techniques for soft tissue and joint mobilization or manual traction. Therapeutic procedures may also include therapeutic activities or self care and home training.

Short-Term Goals: (over the course of the next 3 weeks):
1. Decrease the patient's subjective complaint of pain 1-2 levels on the visual analogue scale.
2. Decrease the patient's score on the Oswestry pain index by 5-10 points.
3. Increase the patient's fascial mobility 1/2 to 1 grade.
4. Increased stability and strength of the lumbosacral spine to prevent excessive mobility in the lumbosacral spine.
5. Increase the patient's ability to sit for longer than 30 minutes without extreme pain.
6. Increase the patient's ability to be up on his feet for longer than 30 to 60 minutes without extreme pain.
7. Increase the patient's ability to sleep for greater than 6 hours without extreme pain.

Long-Term Goals: (over the course of the next 4 weeks):
1. Return the patient to his previous level of functional mobility without pain.
2. Restore the patient's ability to perform activities of daily living without pain.
3. Enable the patient to sit for least 60 minutes without extreme pain

Thank you for the referral and the opportunity to work with Mr. Andrew Gregos at Eschman Physical Therapy, LLC. If you have any questions or comments, please feel free to contact me at 330-372-5800.

Sincerely,

Joseph M. Eschman P.T., G.C.S.
Physical Therapist, Geriatric Certified Specialist

GREGOS, ANDREW 18423
EVALUATION
APRIL 27, 2006

CHIEF COMPLAINT: Left knee pain. He had terrible pain the beginning of March that lasted for several weeks until the point where it is now better. He is an active individual who teaches martial arts. He was limping and could not bend his knee or squat. He had difficulty going up and down steps. He has degenerative disk disease with herniation of the lumbar disks at L3-4 through L5-S1, which he has been having treatment for. He says his left knee is now feeling much better.

The patient's past medical, surgical, and social history are on the chart and were reviewed with the patient today.
Medication list is on the chart and was reviewed.
ROS: 13 system ROS is on the chart and was reviewed with the patient.

PHYSICAL FINDINGS: Good ROM both hips, both knees, and both ankles. Left knee has palpable plica that is slightly tender. No medial or lateral joint line tenderness. No effusion. MCL, LCL, ACL, and PCL are intact to appropriate examination.

IMPRESSION: Plical syndrome left knee.

PLAN: Increase activities as tolerated. I do not anticipate him needing any further treatment. RTO p.r.n.

Thomas B. Jones, Jr., MD./amq

CENTRAL OHIO NEUROLOGICAL SURGEONS

DAVID YASHON, M.D., F.A.C.S., F.R.C.S. (C.) - 224-1720
EDWARD S. SADAR, M.D., F.A.C.S. - EMERITUS
THOMAS HAWK, M.D., F.A.C.S. - EMERITUS
BRADFORD B. MULLIN, M.D., F.A.C.S. - 868-5872
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WILLIAM R. KEMP, M.D., F.A.C.S. - 261-0456
JAMES H. USELMAN, M.D., F.A.C.S. - 261-0048

April 25, 2006

Andrew C. Gregos
3076 Crescent Drive
Warren, OH 44483

Dear Mr. Gregos: **RE: Andrew C. Gregos (DOB: 12-16-55)**

I received an EMG on you dated 12-2-05. It shows definite bilateral carpal tunnel syndrome and a right T1 radiculopathy. At this point you have not had any findings that point to the T1 nerve root on your studies.

If you wish to discuss carpal tunnel surgery, please let me know. Given the change at the right T1 root I believe you should have a repeat MRI for me to see so I can look particularly at the T1 root. Please contact my office so that can be scheduled along with a follow-up appointment with me.

Sincerely,

Bradford B. Mullin, M.D., F.A.C.S.
Director Division of Neurosurgery MCE
Mt. Carmel East Medical Building
BBM / dm

Dictated but not proofread by Dr. Mullin.
D: 04-25-06
T: 04-27-06

cc: Jagdish Patel, M.D.

Eschman
PHYSICAL THERAPY, LLC
2581 North Road N.E.. Suite A, Warren, OH 44483 PH#: 330-372-5800 FAX#: 330-372-5841

September 8, 2005

Bradford B. Mullen, M. D., F. A. C. S.
5965 E. Broad St., Suite 420
Columbus, OH 43213.

Re: Andrew Gregos / Reassessment
Diagnosis: Degeneration of Lumbar Intervertebral Disc.

Dear Dr. Mullen,

Your patient Andrew Gregos was reassessed today, September 8, 2005 after 10 treatments, with the following findings:

Subjective Complaints:

Chief Complaint: The patient's primary complaint continues to be of right-sided low back pain, which the patient generally rates as a 5 or 6 out of 10. The patient has reported significant relief immediately following Lordex decompression treatment.

Objective Measurements:

General Observations and Comments: The patient utilizes the Oswestry pain index to rate his pain as a 14 out of 100 points, whereas initially he rated the pain as 30 out of 100 points.

Active / Passive Range of Motion:

Left Lower Extremity: Straight leg raising ranges from 107 two 114° whereas initially it ranged from 105 to 111°.
Right Lower Extremity: Straight leg raising now ranges from 106 to 120° whereas initially it had ranged from 101 106°.
Thoracolumbar: Flexion at T12 now ranges from 106 to 113°, whereas initially it had ranged from 120 to 121°. Flexion of the sacrum now ranges from 64 to 72°, whereas initially had ranged from 67 to 71°. Extension at T12 now ranges from 33 to 38°, whereas initially had ranged from 20 to 26°. Extension of the sacrum now ranges from 25 to 29°, whereas initially it had ranged from 20 to 26°. Left lateral flexion at T12 now ranges from 28 to 31°, whereas initially it had ranged from 32 to 33°. Left lateral flexion at the sacrum now ranges from 13 to 22°, whereas initially it had ranged from 7 to 9°. Right lateral flexion at T12 now measures from 25 to 28°, whereas initially it had ranged from 26 to 29°. Right lateral flexion of the sacrum now ranges from 13 to 22°, whereas initially it had range from seven to 10°.

Manual Muscle Testing:

Left Lower Extremity: 5/5 regarding hip and knee flexion, extension and hip abduction.
Right Lower Extremity: 5/5 for hip and knee flexion, extension and hip abduction.
Muscle Endurance: Very good.
Joint Examination: SI compression and distraction testing continue to have no significant increases in the patient's pain. Application of passive intervertebral movements does reproduce pain, especially in the lower lumbar region.

Letter To: Dr. Mullen
RE: Andrew Gregos
Dated: 09-08-05
Page II of II

Palpation Examination: Fascial mobility in the thoracolumbar region continues to be slightly restricted however the patient reports no pain with application of crossing and release techniques or during fascial mobility testing.
Gait Analysis: Unremarkable. The patient's primary complaint continues to be of pain during a seated position.

Assessment: The patient's major limiting problem continues to be his complaint of right-sided lower back pain. The patient has reported short-term periods of relief immediately following Lordex decompression treatment. The objective analysis of the patient's pain, utilizing the Oswestry pain index shows that the patient's pain is now roughly 50% of what it was initially. The physical examination of range of motion shows that extension at T12 has improved slightly, along with extension at the sacrum. Other improvements in range of motion have been noticed with regard to left and right lateral flexion at the sacrum. Based on the progress seen thus far, there is a reasonable reason to assume that further progress may occur therefore it is being recommended that treatment be continued as indicated below in the plan of care.

Plan of Care: The patient will be seen 2 times per week for 4 weeks for a physical therapy treatment program to consist of the following:

1. Modalities for relief of pain. Modalities to include Lordex Lumbar Decompression System for mechanical traction, electrical stimulation and ultrasound as needed.
2. Therapeutic procedures, such as therapeutic exercise, neuromuscular re-education, gait training, manual therapy techniques for soft tissue and joint mobilization or manual traction. Therapeutic procedures may also include therapeutic activities or self care and home training.

Short-Term Goals: (over the course of the next 2-3 weeks):
1. Continue to decrease the patient's subjective complaint of pain 1-2 levels on the visual analogue scale.
2. Continue to decrease the patient's score on the Oswestry pain index by 5-10 points.
3. Continue to increase the patient's fascial mobility 1/2 to 1 grade.
4. Continued increased strength and stability of the thoracolumbar spine to prevent excessive repeated hyperflexion and hyperextension strains and sprains.

Long-Term Goals: (over the course of the next 4 weeks):
1. Return the patient to his previous level of functional mobility without pain.
2. Restore the patient's ability to perform activities of daily living without pain.
3. Continue to restore the patient's ability to sit for least 60 minutes without extreme pain.
4. Continue to improve the patient's ability to sleep for greater than 4 hours without extreme pain.

Thank you for the referral and the opportunity to work with Mr. Andrew Gregos at Eschman Physical Therapy, LLC. If you have any questions or comments, please feel free to contact me at 330-372-5800.

Sincerely,

Joseph M. Eschman P.T., G.C.S.
Physical Therapist, Geriatric Certified Specialist

Cc: Anthem / approval for continued visits

Eschman
PHYSICAL THERAPY, LLC

August 9, 2005

Bradford B. Mullen, M. D., F. A. C. S.
5965 E. Broad St., Suite 420
Columbus, OH 43213

Re: **Andrew Gregos / Initial Evaluation**
Diagnosis: **Degeneration of Lumbar Intervertebral Disc**

Dear Dr. Mullen,

Your patient Andrew Gregos was evaluated August 9, 2005, with the following findings:

Subjective Complaints:

Chief Complaint: The patient's primary complaint is of right-sided low back pain, which radiates down into his right buttock and hip area. The patient rates the pain on the visual analogue scale as a 5 out of 10. The patient describes the pain is a constant sharp pain. The patient utilizes the Oswestry pain index to indicate that the pain is moderate. Aggravating factors include primarily sitting, while relieving factors include lying down with his feet elevated. The patient reports that his sleep is disturbed and that he feels his condition is worsening.
Past Medical History: Hypertension.
Past Surgical History: Cervical fusion January of 2004, foot surgery 1985 and 1987, appendectomy 1978, eye surgery 1963.
Medications: Clonidine, Lisinopril, Vytorin, Hydrocodone
Patient's Goals: The patient's goals for therapy are to be able to sit for longer than 30 minutes without severe pain or sleep for longer than 4 hours without pain. The patient also reports he would like to be able to stand or be up on his feet for longer than 30 to 60 minutes without severe pain.

Objective Measurements:

General Observations and Comments: Observations of the patient's posture shows no significant postural faults other than the fact that the patient has a relatively flattened lumbar lordosis. The patient rates his pain on the Oswestry pain index as 30/100 points.

Active / Passive Range of Motion:

Left Lower Extremity: Within functional limits for hip and knee extension, and flexion and hip abduction. Straight leg raising is measured as 101° to 106°.
Right Lower Extremity: Within functional limits for hip and knee extension, flexion and hip abduction. Straight leg raising is measured as 105° to 111°.
Thoracolumbar: Flexion at T12 now ranges from 120° to 121°, whereas sacral flexion is from 67° to 71°. Extension at T12 is measured at 51° to 57°, whereas extension of the sacrum measures from 20° to 26°. Left lateral flexion at T12 ranges from 32° to 33°, whereas at the sacrum it ranges from 7° to 9°. Right lateral flexion at T12 ranges from 26° to 29°, whereas at the sacrum ranges from 7° to 10°.

Manual Muscle Testing:

Left Lower Extremity: 5/5 regarding hip and knee flexion and extension and hip abduction.
Right Lower Extremity: 5/5 for hip and knee flexion, extension and hip abduction.
Lumbar: Extension ranges from 16.4 to 16.9 pounds, whereas flexion ranges from 8.1 to 15.3 pounds.
Muscle Endurance: Very good.
Joint Examination: SI compression and distraction testing produces no significant increases in the patient's pain. Application of passive intervertebral movements does reproduce pain, especially in the lower lumbar region.
Palpation Examination: Fascial mobility in the thoracolumbar region is somewhat restricted however, the patient reports no pain with application of cross hand release techniques or during fascial mobility testing.
Gait Analysis: Unremarkable, the patient's primary complaint is of pain with a seated position.

Letter To: Dr. Bradford Mullen
RE: Andrew Gregos
Dated: 08-09-05
Page II of II

Assessment: The patient's major limiting problem is his complaint of pain in the right side of the low back radiating down into the right buttock. The patient rates the pain on the visual analogue scale as a 5 out of 10. The patient utilized the Oswestry pain index to classify the pain as a moderate pain, and scores the pain as 30 out of 100 points. This score on the Oswestry indicates that the patient has a severe disability. The range of motion analysis shows that the patient is actually hypermobile with regard to flexion at T12 and the sacrum and also extension at T12 and the sacrum. This would seem to indicate that thoracolumbar stabilization exercises may be indicated and may be helpful. The patient will also be cautioned to avoid repeated and extreme end ranges of flexion and extension. Side bending at T12 at the sacrum is actually relatively normal however; the patient does report an increase in pain with right side bending activities. Obviously the patient will be cautioned to avoid such activities. Muscle testing shows that lower extremity strength is at least good if not normal, with regard to hip, knee and ankle strength. Trunk strength also appears to be good however; treatment will focus on the thoracolumbar stabilization exercises to provide stability to this extremely mobile area. Palpation of the thoracolumbar spine shows that the fascia appears to be slightly restricted with regard to a posterior glide of the tissue. Based on the patient's diagnosis and the results of the evaluation today the prognosis for rehabilitation is good based on the plan of care and goals below.

Plan of Care: The patient will be seen as prescribed 2 to 3 times per week for 4 weeks for a physical therapy treatment program to consist of the following:

1. Modalities for relief of pain. Modalities to include Lordex Lumbar Decompression System for mechanical traction, electrical stimulation, including a home tens unit, or ultrasound, as needed.
2. Therapeutic procedures, such as therapeutic exercise, including use of the Lordex Rx 1 for thoracolumbar strengthening, neuromuscular re-education, gait training, manual therapy techniques for soft tissue and joint mobilization or manual traction. Therapeutic procedures may also include therapeutic activities or self care and home training.

Short-Term Goals: (over the course of the next 3 weeks):
1. Decrease the patient's subjective complaint of pain 1-2 levels on the visual analogue scale.
2. Decrease the patient's score on the Oswestry pain index by 5-10 points.
3. Increase the patient's fascial mobility 1/2 to 1 grade.
4. Increased stability and strength of the thoracolumbar spine to prevent excessive repeated flexion and extension activities.
5. Increase the patient's ability to sit for longer than 30 minutes without extreme pain.
6. Increase the patient's ability to be up on his feet for longer than 30 to 60 minutes without extreme pain.
7. Increase the patient's ability to sleep for greater than 4 hours without extreme pain.

Long-Term Goals: (over the course of the next 4 weeks):
1. Return the patient to his previous level of functional mobility without pain.
2. Restore the patient's ability to perform activities of daily living without pain.
3. Enable the patient to sit for least 60 minutes without extreme pain

Thank you for the referral and the opportunity to work with Mr. Andrew Gregos at Eschman Physical Therapy, LLC. If you have any questions or comments, please feel free to contact me at 330-372-5800.

Sincerely,

Joseph M. Eschman P.T., G.C.S.
Physical Therapist, Geriatric Certified Specialist

CENTRAL OHIO NEUROLOGICAL SURGEONS

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JAMES H. USELMAN, M.D., F.A.C.S. - 261-0048
WILLIAM R. KEMP, M.D., F.A.C.S. - 221-2420

July 31, 2005

Jagdish Patel, M.D.
1930 Nile Courtland Rd.
Warren, OH 44484

Dear Dr. Patel: **RE: Andrew C. Gregos (DOB: 12-16-55)**

Andrew Gregos returned to see me today in consultation.

NEUROLOGICAL EXAM: His blood pressure is 177/100 , pulse is 55, temperature is 97.5, height is 6'1'', and weight is 203 lbs. Otherwise his findings are unchanged.

DATA REVIEWED: We discussed the results of his discography. It was positive at L3-4 and L4-5. Radiographically there is deterioration at L3-4, L4-5, and L5-S1.

TREATMENT OPTIONS & PLAN: I explained to him the results of multilevel fusions for disc pain is not good and I generally don't recommend it at three levels. Given the multilevel nature of his disease he is not a candidate for an artificial disc replacement. We did talk about other options including bracing and the Vax-D. I recommend he pursue the Vax-D for traction. He'll see me back in one year.

Sincerely,

BBMullin

Bradford B. Mullin, M.D.
Mt. Carmel East Medical Bldg.
BBM / dm

Dictated but not proofread by Dr. Mullin.

cc: Andrew C. Gregos

CHANDER M. KOHLI, M.D.
Diplomate American Board of Neurological Surgery
Clinical Professor of Neurological Surgery NEOUCOM

JOEL D. SIEGAL, M.D.
Diplomate American Board of Neurological Surgery
Assistant Professor of Neurological Surgery NEOUCOM

ANAND G. GARG, M.D., PHD
Assistant Clinical Professor of Neurological Surgery NEOUCOM

Microneurosurgery • Pain Management • Spine Surgery • Stereotaxis

CHANDER M. KOHLI, M.D., F.A.C.S., INC.

OFFICE NOTE

NAME: ANDREW GREGOS
DATE SEEN: MARCH 7, 2005 – CORTLAND OFFICE

Mr. Gregos is being seen today in follow-up. He had the lumbar myelogram which showed significant L4-5 degenerative disc disease and a mild L4-5 disc protrusion off laterally to the right. He has no significant facet arthropathy. We did discuss the myelogram at length as well as the MRI.

At this point he would be a good candidate for a disc replacement because he has significant back pain which is constant and worsened with activity and even at present at rest. He has minimal leg discomfort. We would recommend an anesthetic discogram at L4-5 and then revisit afterwards for discussion regarding a disc replacement. We discussed the options, risks and benefits of the discogram and it's use in workup of the disc replacement surgery. He will consider this and get back with us.

JDS:ct

Dictated in front of the patient but not read by Dr. Siegal.

cc: Dr. Jagdish Patel

540 Parmalee Ave., Suite 310
Youngstown, Ohio 44510
330-747-1420
(Main Office)

1280 Boardman-Canfield Rd.
Boardman, Ohio 44512
330-747-1420

Fax: 330-747-1151

2600 Elm Rd., N.E.
Cortland, Ohio 44410
330-747-1420

CHANDER M. KOHLI, M.D.
Diplomate American Board of Neurological Surgery
Clinical Professor of Neurological Surgery NEOUCOM

JOEL D. SIEGAL, M.D.
Diplomate American Board of Neurological Surgery
Assistant Professor of Neurological Surgery NEOUCOM

ANAND G. GARG, M.D., PHD
Assistant Clinical Professor of Neurological Surgery NEOUCOM

Microneurosurgery • Pain Management • Spine Surgery • Stereotaxis

CHANDER M. KOHLI, M.D., F.A.C.S., INC.

RE: ANDREW GREGOS
PAGE 2

PHYSICAL EXAM: Blood pressure: 139/95. Pulse: 78. Respirations: 12. General Appearance: He is a well-developed male in no apparent distress who stands at 6' 1" and weighs 190 pounds. Neuro: Alert and oriented with fluent speech, recent and remote memory, attention span and concentration, language and fund of knowledge are normal. The pupils are equal, round and reactive to light; extraocular movements are intact. Facial sensation is normal. The face is symmetric. Hearing is normal bilaterally. The palate is symmetric. Shoulder shrug 5/5. The tongue is midline. Motor is 5/5 bilaterally in the upper and lower extremities with normal bulk and tone. Sensation is normal to light touch in both upper and lower extremities. Deep tendon nerve reflexes were 2/4 throughout bilateral upper and lower extremities with toes down going. Finger-nose-finger is normal. Moderate right paraspinous lumbar pain with palpation.

STUDIES: MRI was reviewed as was the report from 12/16/04 which shows L4-5 degenerative disc disease moderate and mild L5-S1 degenerative disc disease with mild disc protrusions. Mild posterior facet arthropathy.

IMPRESSION:
1) Degenerative disc disease L4-5 greater than L5-S1.
2) Mild L4-5 and L5-S1 disc protrusion.

Mr. Gregos is a 49-year-old gentleman who has moderate low back pain and right leg discomfort. I feel that he would definitely be an L4-5 disc replacement candidate pending the outcome of a CT of the lumbar spine and a discogram. However, I am not sure that his symptoms are bad enough at this point to warrant such intervention. I therefore am recommending a three-day epidural nerve block, physical therapy to compliment his martial arts training, Medrol Dose Pack, Mobic 15 mg. po qd and Robaxin 750 mg. 1-2 po tid. He will then follow-up with me in six weeks.

Thank You.

JDS:ct
Dictated but not read by Dr. Siegal.

140

HUMILITY OF MARY HEALTH PARTNERS
St. Joseph Health Center
MEDICAL IMAGING REPORT
C. Walker,MD - R.P.Brennan,MD - P.M. Kanistros,MD - J.E. Martinez-Llorens,MD

Account # 0435100019 Unit Number J00060340
PATIENT GREGOS,ANDREW C LOC OPJ Sex: M DOB 12/16/55
Work Diag: DEGENERATIVE DISC LUMBAR
Ord Diag: DDD LUMBAR
PCP:
Adm: PATEL,JAGDISH H 1455 PARKMAN RD WARREN OH 44485
REF:
ORD: PATEL,JAGDISH H 1455 PARKMAN RD WARREN OH 44485

PERF DATE/TIME: 12/16/04 1502 PT TYPE: OPJ

Chk-in #	Order	Exam	
2032049	0001	36045	MRI SPINE LUMBAR W/O CONTRAST
			Ord Diag: DDD LUMBAR

MRI Lumbar Spine Without Contrast:

There is degenerative arthritis at L4-5 of moderate severity and mild degenerative arthritis at L5-S1. There is no disk protrusion, extrusion or spinal stenosis. No lateral recess narrowing is demonstrated.

Impression: Degenerative arthritis at L4-5 and L5-S1. No disk herniation.

/Read By/ RONALD P BRENNAN, M.D.
/Released By/ RONALD P BRENNAN, M.D.
Released 12/16/04 1606
RPB

FINAL

South Texas Orthopaedic and Spinal Surgery Associates, P.A.
9150 Huebner Rd Ste 350 San Antonio TX 78240-1551
Phone: (210) 561-7234 FAX: (210) 561-7240

Patient Name:	Andrew C. Gregos	Chart Number:	142062
Examination Date:	January 26, 2004	Examination Type:	Multisystem Initial Visit
Examining Doctor:	John W. Brantigan, M.D.		

CHIEF COMPLAINT: 47-year-old male with right shoulder and arm pain.

HISTORY: The patient states that in November 2002 he awoke from sleep with numbness in his left hand. He was seen in the emergency room, where he had an MRI scan and a CT scan and was hospitalized with the possibility of a stroke. His numbness resolved. A short time later he developed pain in the right arm, which has been his principal complaint. He estimates that he has seen at least 15 physicians. He was seen at the Cleveland Clinic by a surgeon, Dr. Carmen, who referred him to Richard Lederman, a neurologist. Dr. Lederman did an EMG study, and the patient has had an estimated three EMG studies, all of which were apparently normal. He has had numerous studies, including a carotid duplex. Bilateral subclavian arteriograms were normal. He was seen by a neurosurgeon, Dr. Morris Pulliam. An MRI scan of the neck showed spondylosis between C4 and C7. Mr. Gregos consulted my brother, Dr. Charles Brantigan, a vascular surgeon in Denver, Colorado, who did an evaluation for thoracic outlet syndrome. This included high-resolution CT of the thoracic outlet and physical examination, both of which were negative.

CURRENT SYMPTOMS: At the present time, the pain is largely in the mid-portion of the right upper arm in the medial aspect above the elbow radiating somewhat to the pectoral muscle. He has a slight degree of the same findings on the left side. He has episodes of periodic numbness at night. He also has had episodes of low back pain, which are not a major problem for him. The pain is reduced on the use of ice and heat. The pain is constant, but worse with lifting and especially with extending his arms in front of him and is worse on driving a motor vehicle. In addition to the medications listed below, he has used Vioxx and Ultracet for his arm pain, which have not been helpful. He has also had physical therapy and epidural blocks for his arm pain, and these have not been helpful.

PAST MEDICAL HISTORY: Operations: He had an appendectomy in 1978, foot surgery in 1984, and bilateral neuromas removed from his feet in 1986, an operation which was quite successful. He had eye surgery for ambiopia in 1962 and wisdom teeth extraction. Current Medications: Clonidine, Zocor, Lisinopril, aspirin, and multivitamins. Allergies: He states that he is allergic to Tolectin, bee stings, and spider bites. He has no known metal sensitivities. Review of Systems: Positive for elevated blood pressure and cholesterol.

SOCIAL HISTORY: He is an engineering manager. He is also a martial arts participant.

January 26, 2004 initial visit continued:

PHYSICAL EXAMINATION: Blood pressure is 130/90 and pulse 82. Height is 5'11" and weight is 214 lb. Mr. Gregos has full normal range of motion of his cervical spine with no discomfort or pain in his neck. He has full motion of the shoulders, elbows, and wrists. There is tenderness in the medial aspect of the upper arm on the right side. I do not feel any masses or abnormal swellings. Compression of the humerus causes no pain. Two-point sensory examination in the hands is intact. Tinel's sign and Phalen's sign are negative at the wrist. Motor strength is full in the major muscle groups of the upper extremities. Testing of motor strength does not particularly produce discomfort. Elevated arm exercise test as described by Dr. Charles Brantigan does produce pain in the right brachial area radiating to the pectoral area followed by some sensation of subjective numbness in the hands, but otherwise the thoracic outlet tests are negative.

IMAGING STUDIES: Imaging studies include x-rays of the cervical spine, which show significant spondylosis, particularly at C5-6 and C6-7 with a degree of kyphosis in these two levels. An MRI scan provided with the patient shows major posterior disc bulges of C5-6 and C6-7 with a degree of degeneration. The degree of degeneration at other levels is unremarkable. The patient had a repeat of his MRI scan done today, which shows similar findings as compared with the previous study. A cervical discogram done today by Dr. Joyner showed degenerative change consistent with the MRI scan. There was no production of axial neck pain and no production of arm pain. I have discussed these findings with both Dr. Robert Joyner, an anesthesiologist, and Dr. Robert Cone, a radiologist. Dr. Joyner reports that discography rarely reproduces nerve pain in cervical discs. Dr. Cone reported that he sees no area of particular nerve compression on the MRI studies. An MRI scan of his lumbar spine shows severe degenerative disc disease L4-5 with loss of disc height and Modic changes. An x-ray of the right humerus shows no bony abnormalities.

IMPRESSION:

1. Severe degenerative disc changes C5-6 and C6-7.
2. Right brachial arm pain.

DISCUSSION:

We discussed the possibility of local pathology in the area of tenderness and pain. This could be studied with an MRI scan to evaluate the soft tissues. The yield of this would be very low, since the x-ray is normal and there are no palpable abnormalities. Also, since the patient is developing similar symptoms to a lesser degree in the opposite arm, it is more likely from a central pathology. Arm pain is certainly associated with disc degeneration and herniation, and this is the most likely etiology. However, the character of his pain and the presence of tenderness in the brachial area are somewhat atypical. I believe that our choice is to proceed with anterior cervical discectomy and fusion and C5-6 and C6-7, knowing that it is impossible to predict whether or not this will give him any benefit whatsoever in his arm pain.

January ~~27~~ 26, 2004 initial visit continued:

The alternative would be to pursue further conservative treatment with medication and/or therapy, which has already been basically a failure. I do not know of any other specialists who could shed further light on his diagnostic situation, and certainly he has been to see many individuals.

After a lengthy discussion, the patient stated that he would prefer to have the anterior cervical discectomy and fusion, understanding the uncertainty about pain relief. He has traveled from the Warren, Ohio area and he requested that this be done immediately within the next several days so that he would not have to make a separate trip. We will tentatively plan to do the surgery on Wednesday. He understands the risks and limitations and desires to proceed.

John W. Brantigan, M.D.
JWB/tjh
cc: Charles Brantigan, M.D.

February 5, 2004 office visit: Mr. Gregos had his surgery, including anterior cervical discectomy and fusion at C5-6 and C6-7. After surgery he had immediate, complete relief of his arm pain. Today he remains extremely happy with his result. The wounds are well healed. Sutures were removed. He has some tenderness over the bone graft site in his hip area, but no difficulty with walking. There is a degree of mild residual aching in his arms, which is trivial when compared to his preoperative pain level. X-rays of the cervical spine taken today show excellent position of the cages at C5-6 and C6-7. I have measured the segmental lordosis C5 through C7 at 10° today. This is compared with a 25° kyphosis on the films prior to surgery, a 35° improvement in alignment. He will be returning to his home in Warren, Ohio. He should wear a cervical collar full time for a month. He should send me x-rays of the cervical spine in one month and we will consult by telephone.

John W. Brantigan, M.D.
JWB/tjh
cc: Patel Jagdish, M.D.

SOUTH TEXAS RADIOLOGY IMAGING CENTERS

E-1230740

Huebner Imaging Center * 9150 Huebner Road * San Antonio, TX 78240
(210) 561 7170 * Fax (210) 561 7179

GREGOS, ANDREW C

MR Cervical Spine
26-Jan-2004 9:00 AM

MR Lumbar Spine
26-Jan-2004 9:00 AM

D00430194
Exam Site: H
Status: O
DOB: 16-Dec-1955 Sex: M
Age: 48 Years
Requester: Brantigan, John W, M.D.

Reason for Exam:
CERVICAL AND LUMBAR PAIN

IMAGING CONSULTATION
Final Report

MR OF THE CERVICAL AND MR OF THE LUMBAR SPINE:

TECHNIQUE: Routine MR examination is performed of the cervical and lumbar spine.

MR OF THE CERVICAL SPINE:

Visualized posterior fossa structures had normal morphology. The cervical spinal cord was normal in morphology and signal characteristics. Mild degenerative changes of the atlantoaxial articulation.

C2-3: Mild to moderate disc degeneration with moderate size right sided uncovertebral joint osteophyte and mild right foraminal stenosis. No significant central or left foraminal stenosis.

C3-4: Mild to moderate disc degeneration with 2 to 3 mm of anterolisthesis. Small bilateral uncovertebral joint osteophytes, but significant central or foraminal stenosis.

C4-5: Mild disc degeneration with 2 mm of anterolisthesis. Small posterior annular disc bulge more prominent on the left. No significant central or foraminal stenosis.

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FR MEDICAL RECORD COPY

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C5-6: Moderate disc degeneration with 2 to 3 mm in size left paracentral broad based disc bulge or disc protrusion. There is slight inferior extrusion of the disc material to the right of midline. Large volume of central spinal canal with only mild central spinal stenosis. Mild left foraminal stenosis. No significant right foraminal stenosis.

C6-7: Moderate to severe degenerative disc disease with normal sagittal plane alignment. Two to three millimeter in size posterior marginal osteophyte with mild central spinal stenosis and mild right foraminal stenosis due to uncovertebral joint osteophyte. No significant left foraminal stenosis.

C7-T1: Moderate disc degeneration with 2 mm of anterolisthesis. Moderate size broad based annular disc bulge. No significant central or foraminal stenosis.

IMPRESSION: SPONDYLOSIS CHANGES WITH MODERATE RIGHT FORAMINAL STENOSIS OF C3-4 AND C4-5.

MR LUMBAR SPINE:

Conus medullaris had normal position and morphology. The nerve roots are peripherally distributed in the thecal sac and may be mildly thickened. This could be seen with very mild arachnoiditis.

L1-2: Mild disc desiccation. Otherwise, negative.

L2-3: Mild disc desiccation. Otherwise, negative.

L3-4: Mild disc degeneration with small broad based annular disc bulge. No significant central or foraminal stenosis. Mild bilateral facet joint osteoarthritis.

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L4-5: Severe disc degeneration with normal sagittal plane alignment. There is congenitally small spinal canal with small broad based annular disc bulge. A 2 mm ventral impression of the thecal sac. No significant central stenosis. Mild bilateral foraminal stenosis. There is posterior central annular tearing associated with the annular disc bulge. Mild bilateral facet joint osteoarthritis.

L5-S1: Moderate disc degeneration with normal sagittal plane alignment. There is small to moderate size broad based annular disc bulge with right paracentral annular tear. A 2 mm ventral impression of the thecal sac. No significant central or foraminal stenosis. Facet joint trophism and hypoplastic facet joints. This is probably a transitional segment.

IMPRESSION: LUMBAR SPONDYLOSIS CHANGES WITH ANNULAR DISC BULGES OF L4-5 AND L5-S1 AND ASSOCIATED ANNULAR TEARS.

Interpreted by: Douglas K Smith, M.D. /signed by/ SMITH, DOUGLAS K, M.D.

Transcribed on: 26-Jan-200410:48 AMby Linnea Gardner 1230740
Finalized on: 27-Jan-200410:55 AM by Douglas K Smith, M.D.
Attending MD: Brantigan, John W, M.D.

PR MEDICAL RECORD COPY

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April 26, 2004 office visit:
Mr. Gregos is now three months postop ACDF C5-6 and C6-7 with cages. He has had dramatic improvement of his pain, but has some mild amount of residual discomfort in the right shoulder and upper brachium. This is gradually subsiding. He is not taking any pain medications. He has lost 26 lb in weight. X-rays of the cervical spine show full healing of the cervical fusions.

We discussed his lumbar condition. His MRI scan shows severe degeneration at L4-5 with Modic changes. At some point he will require cage fusion L4-5. I have given him a reprint of our FDA study article, a brochure, and a copy of the ten-year poster. He has some episodes of some very severe pain in a background of fairly constant lower grade pain. He will let us know if and when he feels it is necessary to proceed with surgery. I gave him a note releasing him to return to work on 05-17-04. He should either return for recheck in three months or send the x-rays and we will talk by telephone.

John W. Brantigan, M.D.
JWB/tjh
cc: Patel Jagdish, M.D.

July 28, 2004 telephone conference: Mr. Gregos is now six months postop. He sent us x-rays dated 7/20/04. These show complete healing of C5-6 and C6-7 fusions. There is some degeneration at C7-T1 below the fusion. This is basically unchanged compared with his pre-operative studies. He states that he is very happy with his results. He has no sharp stabbing pain whatsoever. The pain in his left shoulder and arm are completely dissolved. He does have episodes of much lesser discomfort in the right arm. I feel that this is possibly due to the C7-T1 level, and he should consider using an anti-inflammatory such as Celebrex. He will consult his family doctor regarding this. He will let us know if he has further difficulties.

John W. Brantigan, M.D.
JWB/cds
cc: Patel Jagdish, M.D.